

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 & 15 Form 6387-11-18/66mb

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Somerset</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i> One week	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural <i>Rockwood</i> 75-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>	d. STREET ADDRESS <i>Rt. # 2</i>				
3. NAME OF DECEASED (Type or print) <i>ROBERT LEE BAER</i>	4. DATE OF DEATH Nov. 6 1966				
5. SEX <i>M</i>	6. COLOR OR RACE <i>Caucas.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 27, 1931</i>	9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Disabled Veteran</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Somerset Co. Penn.</i>	12. CITIZEN OF WHAT COUNTRY? <i>A. S.</i>		
13. FATHER'S NAME <i>Leo Baer</i>	14. MOTHER'S MAIDEN NAME <i>Irene Thomas</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>	16. SOCIAL SECURITY NO. <i>728-03-8418</i>	17. INFORMANT <i>Mary C. Baer (same) wife</i>			
Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>345X</i> DUE TO <i>chronic Pyelonephritis = Renal Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>few weeks</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Multiple Sclerosis = Cord Bladder</i> 10 years + (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 31, 1966</i> , to <i>Nov. 6, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 6, 1966</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>W. J. Riddick</i>		22b. DATE SIGNED <i>Nov. 6, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>W. J. Riddick, M. D.</i>		22d. ADDRESS <i>Frederick Medical Center, Frederick, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 10, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Philips & James Catholic Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Meyersdale, Pa</i>	
24. FUNERAL DIRECTOR <i>Donald M. Etchison</i>		ADDRESS <i>M. R. Etchison & Son, Frederick, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 10 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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19862 19863 19864

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15619

CERTIFICATE OF DEATH

15622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or disposal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 6 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 519 North Market Street				d. STREET ADDRESS 519 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First MARY	Middle BELL	Last BARNHOUSE	4. DATE OF DEATH November 30, 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. OATE OF BIRTH 8 June 1893	9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Calvin Boone		14. MOTHER'S MAIDEN NAME Liza Sickle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219 12 0021B		17. INFORMANT Address James W. Barnhouse (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension & infarction 5 weeks ago</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i>By drowning & suffocation</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <i>factory</i>	20f. (City or town) Frederick	(County) (State) Md.
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 17, 1966</i> to <i>11-30, 1966</i> , that (I) (we) last saw the deceased alive on <i>11-20, 1966</i> , and that death occurred at <i>3:35 P.M.</i> from the causes and on the date stated above.				22b. DATE SIGNED 1 Dec 1966	
22a. SIGNATURE <i>Thomas E. Stone</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. ATTENDING PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS 4 W. 3rd St., Frederick, Md. 21701			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/66	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR <i>Franklin R. Smith Jr.</i>		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR DEC 5 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and many event within 72 hours after death.

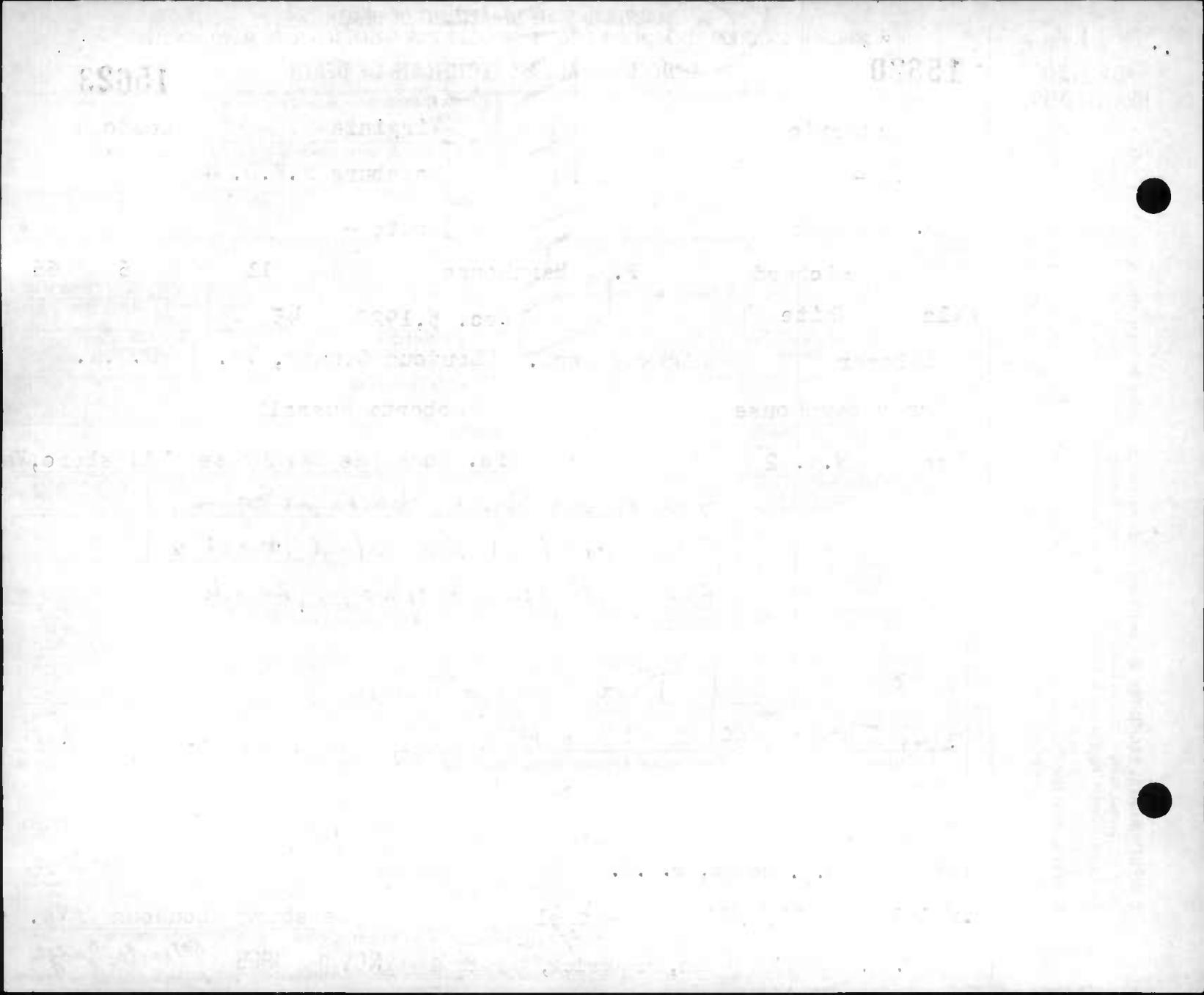
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15620

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15623

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY Loudoun					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -		c. LENGTH OF STAY IN lb Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leesburg R.F.D. 4							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nr. Brunswick		d. STREET ADDRESS Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Richard		First P.	Middle Barnhouse	Last 11	4. DATE OF DEATH Dec. 5, 1920	Month 11	Day 6	Year 1966			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1920	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Highway Dept.		11. BIRTHPLACE (State or foreign country) Loudoun County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Harry Barnhouse		14. MOTHER'S MAIDEN NAME Roberta Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 2		16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Anna Mae Barnhouse	Address Hillsboro, Va
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull, Fractured Spine, 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Crushed Chest, Lacerated Heart & DUE TO (c) Lungs, Ruptured Diaphragm; Liver.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Leesburg		(County) Frederick	(State) Md.
20c. TIME OF INJURY Month, Day, Year Hour 3:45 P.M. 11-6-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Leesburg		(County) Frederick		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED 11-6-66	
ACTUAL SIGNATURE B.O. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) B.O. Thomas, Sr. M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/66		23c. NAME OF CEMETERY OR CREMATORIAL Bethel		23d. LOCATION (City or Town) Leesburg		(County) Loudoun		(State) Va.	
24. FUNERAL DIRECTOR Charles M. Etchison & Son, Frederick, Maryland		ADDRESS Fidelity		25a. REC'D BY REGISTRAR NOV 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15621

CERTIFICATE OF DEATH

15624

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

1 day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

JOHN LESLIE BIDDINGER

Last

4. DATE
OF
DEATH

Nov.

3 1966

5. SEX

m

6. COLOR OR RACE

w

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

Jan. 5, 1895

9. AGE (In years
last birthday)

71 yrs.

IF UNDER 1 YEAR

Months Dey Hours Min.

e. IS RESIDENCE
ON A FARM?

YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Tenant

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John A. Biddinger

14. MOTHER'S MAIDEN NAME

Ida Eaves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

220-01-1252 Mrs Carl Boone, Keymar Rd, Md.

INTERVAL BETWEEN
ONSET AND DEATH

2 days

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Bilateral pneumonia, lower lobe

4221

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

Arteriosclerotic cardiovascular disease

with congestive myocardial failure

5 years

(c)

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Severe anemia, due to hemorrhage etiology undetermined

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

2Dd. INJURY OCCURRED

While at work Not While at work

at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

2Dd. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

2Dd. INJURY OCCURRED

While at work Not While at work

at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

Jan. 1966, to Nov. 1966, that (I) (we) last

saw the deceased alive on.....

Nov. 1966, and that death occurred at 8:45 A.M. from the causes and on the date stated above.

22e. SIGNATURE

James E. Stover, Jr.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

11/4/66
22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

JAMES E. STOVER, JR.

22d. ADDRESS

WALKERSVILLE, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/6/66

23c. NAME OF CEMETERY OR CREMATORIUM

Chapel Cem.

23d. LOCATION (City, town or county)

M. Libertytown, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

G. S. Barton

ADDRESS

Walkersville, Md.

25e. REC'D BY REGISTRAR

NOV 7 1966

25b. REGISTRAR'S SIGNATURE

J. Charles Judge

1961

1961

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15622

CERTIFICATE OF DEATH

15625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Monocacy Hall Nursing Home paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)											
a. COUNTY		a. STATE Maryland b. COUNTY Frederick											
Frederick		c. LENGTH OF STAY IN lb											
		4 years											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Frederick		Frederick											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS											
Monocacy Hall Nursing Home		911 Motter Place											
e. IS RESIDENCE ON A FARM?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
J. Adney Biddle					Nov.	23-	19	66					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 18- 1873	93 yrs.	Months	Days	Hours	Min.				
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Retired- Minister		-----		New Philadelphia- Ohio		U. S. A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Jonathon Biddle		Polona Reynolds											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		220-44-2422		Mrs. N. Edward Lightner-911 Motter Place-		Frederick- Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (e)		1 day											
422.1		Arterial thrombosis											
DUE TO		Arterio-sclerotic Cardiovascular											
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		10+ yrs.											
{		}											
(c) DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED?											
Chronic lymphatic leukemia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20e. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
19				1962		19 Nov. 1966							
21. I certify that (I) (this hospital) attended the deceased from.....		to 23 Nov. 1966		that (I) (we) last saw the deceased alive on.....		14:30A		from the causes and on the date stated above.					
22. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED			
Dr. Charles H. Conley, Jr.				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Nov. 23-1966			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS											
Dr. Charles H. Conley, Jr.		Prof. Bldg.- Frederick, Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)					
Burial		Nov. 25-1966		Mt. Olivet Cemetery		Frederick, Md. 21701							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Elwood T. M.R. Etchison & Son		Whitmore		DATE NOV 28 1966		Charles Judge							
VR A15 (4)													
20M S-63													

2512

25001

DO. COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15623

CERTIFICATE OF DEATH

15626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Hours	b. COUNTY Frederick	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 135 W. Patrick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MILLARD	First M.	Middle BRUST	4. DATE OF DEATH Month November
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. AGE (In years last birthday) 71 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Canning Co.		11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	
13. FATHER'S NAME Henry Brust		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # 1 220 01 5644	
17. INFORMANT Mrs. Margaret N. Brust (Same as item # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Atherosclerosis / Heart Disease stating the underlying cause } (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/19 1966 to 11/19 1966 , that (I) (we) last saw the deceased alive on 11/19 1966 , and that death occurred at 11:15 AM , from causes and on the date stated above.			
22a. SIGNATURE James B. Thomas,		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22b. DATE SIGNED 11-19-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 22, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery
24. FUNERAL DIRECTOR Donald M. Etchison		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR NOV 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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15624

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15627

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		d. STREET ADDRESS <i>619 Lee Place</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Mem.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EDWARD</i>		First <i>E</i>	Middle <i>W</i>
4. DATE OF DEATH <i>NOV. 7 1966</i>	Month <i>NOV.</i>	Day <i>7</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 13, 1911</i>
9. AGE (In years last birthday) <i>54</i>	10. KIND OF BUSINESS OR INDUSTRY <i>PHYSICAL Scientist U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>Boston Mass.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>David ?</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Steinberg</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>	16. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>WWII 1936-1944 022-16-8256</i>	17. INFORMANT <i>Mildred A. Cherry</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>b</i> <i>c</i>
			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <i>11-7-66</i>
EXAMINER'S NAME (Type) <i>B.O.Thomas, Sr.M.D.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-10-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>SHARON MEMORIAL</i>	23d. LOCATION (City or Town) (County) (State) <i>SHARON MASS.</i>
24. FUNERAL DIRECTOR <i>SALAMONE FUNERAL HOME</i>	ADDRESS <i>FREDERICK MD.</i>	25a. REC'D BY REGISTRAR <i>NOV 10 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1521

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15628

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Plane # 4		c. LENGTH OF STAY IN 1b 10.1		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Plane # 4		d. STREET ADDRESS R.F.D. # 1, Mt. Airy		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 1, Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jesse		First -	Middle Clay	
4. DATE OF DEATH Nov. 12 1966	Month Nov.	Day 12	Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1893	
9. AGE (In years lost birthday) 73 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) Kempton, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nelson Clay	14. MOTHER'S MAIDEN NAME Isabelle Purdum	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 214-36-2488	17. INFORMANT Mrs Bessie V. Clay, Item 2	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. Arteriosclerotic Heart Disease (b) OUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>B.C. Thomas</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 11/12/66
EXAMINER'S NAME (Type) <i>B.C. Thomas, M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ODEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Marvin Chapel	23d. LOCATION (City or Town) (County) (State) Plane # 4, Maryland.	
24. FUNERAL DIRECTOR <i>Olin L. Molesworth, Damascus, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR NOV 15 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15626

CERTIFICATE OF DEATH

15629

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 2/28/63		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 340 East Third Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monocacy Hall Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDGAR	Middle SPONSELLER	Last CROMWELL	4. DATE OF DEATH November 29, 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Nov 1879	9. AGE (in years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brush Company		11. BIRTHPLACE (County & State, or foreign country) Pearl, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Curtis A. Cromwell		14. MOTHER'S MAIDEN NAME Annie Elizabeth Sponseller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214 10 1996		17. INFORMANT Mrs. Louise S. Oden, Ijamsville, Md. 21754		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Cerebral thrombosis							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Cerebral Arterio-sclerosis 10 years. INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9pm - 15 , 19 66 , to Nov. 21 , 19 66 , that (I) (we) last saw the deceased alive on Nov. 20 19 66 , and that death occurred at 1:30P M, from the causes and on the date stated above.							
22a. SIGNATURE Bernard O. Thomas Jr.		M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 30 Nov 1966			
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/66		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		ADDRESS		25a. REC'D BY REGISTRAR DEC 2 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

18061

66831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			15630								
15627								2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)															
a. COUNTY FREDERICK				b. STATE MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				d. STREET ADDRESS 28 MAPLE AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 1 day				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FREDERICK MEMORIAL HOSPITAL															
3. NAME OF DECEASED (Type or print) SHERRY LEE CRUM				First Middle Last SHERRY LEE CRUM				4. DATE OF DEATH 11 27 1966				Month Day Year											
5. SEX F				6. COLOR OR RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11/26/66				9. AGE (in years last birthday) IF UNDER 1 YEAR yrs. Months Days Hours Min. 1 / 1 / 0 / 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? FREDERICK MD.											
13. FATHER'S NAME GARY WAYNE CRUM				14. MOTHER'S MAIDEN NAME MARY ELLEN FOGLE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT MRS. IDA RAMSBURG, WALKERSVILLE MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Donatutty (BW - 567 grams)				DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 26, 1966 , to Nov 27, 1966 that (I) (we) last saw the deceased alive on Nov 27, 1966 , and that death occurred at 9:45 PM , from the causes and on the date stated above.				22a. SIGNATURE J. F. Baker				22b. DATE SIGNED Nov 27, 1966				22c. PHYSICIAN'S NAME (Type) J. F. BAKER				22d. ADDRESS FREDERICK MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF 11/28/66				23c. NAME OF CEMETERY OR CREMATORIAL chapel cemetery				23d. LOCATION (City, town or county) (State) Mr. Libertytown, Md.											
24. FUNERAL DIRECTOR J. C. Barton, Walkersville, Md.				ADDRESS				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE											
								DATE DEC 1 1966															

1821

1821

ANNUAL PROGRAM ACT 1974

Sept 15 1974

1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15631

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1 Myersville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KENNETH First EUGENE Middle FISHER		4. DATE OF DEATH Month November Day 24 , Year 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH October 13, 1948
9. AGE (In years lost birthday) 18 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Oscar W. Fisher		14. MOTHER'S MAIDEN NAME Hazel Summers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. 214-48-4298	
17. INFORMANT Linda Lou Fisher,		Address Route #1 Myersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Accidental Gunshot Wounds to Abdomen.			
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 p.m. 11/24 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Myersville, Fred. Co. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frederick, Md.	
22. DATE SIGNED 11/24/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL Harmony Church of Bretheran.		23d. LOCATION (City or Town) (County) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland		ADDRESS NOV 28 1966	
		25a. REC'D BY REGISTRAR DATE	
		25b. REGISTRAR'S SIGNATURE Charles J. Gage	

1630

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15629

CERTIFICATE OF DEATH

15632

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodsboro</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN lb <i>7 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodsboro</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>EMMA</i>	Middle <i>CARRIE</i>	Last <i>FOGLE</i>
4. DATE OF DEATH	Month <i>Nov.</i>	Year <i>1966</i>	Day
5. SEX	6. COLOR OR RACE <i>F W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16 1881</i>
9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hezekiah Fox</i>		14. MOTHER'S MAIDEN NAME <i>Mary Matilda Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>-</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO <i>Arterio-sclerotic C.V.D.</i>	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Cerebral arterio-sclerosis & dementia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1966</i> to <i>Nov. 1, 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 27, 1966</i> , and that death occurred at <i>7:50 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>11/3/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Bernard O.T. Thomas Jr. M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>Professional Bldg. Fred., Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/4/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Hope</i>		23d. LOCATION (City, town or county) (State) <i>Woodsboro md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>G. E. Barton, Walkersville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 4 1986</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

56061

Page 1

ANDREW JACKSON

102

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15630

15633

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

FREDERICK

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

JOHNSVILLE

c. LENGTH OF STAY IN lb

YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

UNION BRIDGE RURAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

MARYLAND FREDERICK

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

JOHNSVILLE

101

d. STREET ADDRESS

UNION BRIDGE RURAL

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

Last

4. DATE
OF
DEATH

Nov. 27

Month Day Year

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

AUG 16-1899

9. AGE (In years
last birthday)

67 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE AT HOME

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

EDWARD F. CRAWMER

14. MOTHER'S MAIDEN NAME

AMELIA STEINBERG

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

NO

705-10-4907

SAMUEL E. FOGL

JOHNSVILLE MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congitive myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH

6 weeks

443X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Arteriosclerotic cardiovascular disease

DUE TO

(c)

Hypertensive cardiovascular disease

10 year

15 year

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from August 1966 to Nov. 1966, that (I) (we) last saw the deceased alive on Nov. 1966, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE

James E. Stoner Jr.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

11/28/66

22c. PHYSICIAN'S
NAME (Type)

JAMES E. STONER, Jr.

22d. ADDRESS

WALKERSVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 11-30-66

23b. DATE THEREOF

GREENWOOD

23c. NAME OF CEMETERY OR CREMATORIAL

CARROLL COUNTY MD

(State)

ADDRESS

Hartfords UNION BRIDGE MD

23d. LOCATION (City, town or county)

CHARLES JUDGE

(State)

DATE

DEC 1 1966

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10001

10001

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15631

CERTIFICATE OF DEATH

15634

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN lb 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Guy Troxell Frushour		First Guy	Middle Troxell
4. DATE OF DEATH Month Nov. Day 7 Year 1966		Lost	
S. SEX male	6. COLOR OR RACE white	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 24, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysses Grant Frushour		14. MOTHER'S MAIDEN NAME Catherine Main	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWI		16. SOCIAL SECURITY NO. 213-34-2287	17. INFORMANT Miss Mary Frushour Address Graceham, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eastrie Hemmorage - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Anemia - Diabetes - Chronic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Injury occurred from	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Thurmont
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 to Nov , 1966 that (I) (we) last saw the deceased alive on 11/5/66 , 19, and that death occurred at 98 M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Thomas A. Love		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas A. Love		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-66	23c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery
23d. LOCATION (City or Town) (County) (State) Lewistown Fred. Co. Md.		23e. REC'D BY REGISTRAR DATE NOV 10 1966	
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge

6621

8700 100000000

7631

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146</td

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15632

CERTIFICATE OF DEATH

15635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Jefferson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		10.1	
3. NAME OF DECEASED (Type or print)		First Annie	Middle Hine	Last Fry	4. DATE OF DEATH November 18- 19 66	Month Dey Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17- 1883	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Dey Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emanuel Hine				14. MOTHER'S MAIDEN NAME Mary Catherine Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-9990		17. INFORMANT Mrs. Effie A. Roderuck- Jefferson, Md. 21755		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Acute decompensation w/ Pulmonary edema</i>		DUE TO (b) <i>Advanced Coronary Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (c) <i>Hemangiolysis arteriosclerosis</i>		DUE TO (c) <i>Hemangiolysis arteriosclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (I) <i>Sendely</i>							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1/18/66</i>					
20c. TIME OF INJURY Hour e.m. p.m.	Month, Dey, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/1/66, to 11/1/66, that (I) (we) last saw the deceased alive on 1/18/66, and that death occurred at 10:15 AM from the causes and on the date stated above.							
22e. SIGNATURE <i>Dr. A. Talbot Brice M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 18-66	
22c. PHYSICIAN'S NAME (Type) Dr. A. Talbot Brice		22d. ADDRESS Jefferson, Maryland 21755					
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21-1966		23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION (City, town or county) Jefferson, Md. 21755	
24 FUNERAL DIRECTOR'S SIGNATURE M.R.Etchison & Son		ADDRESS Frederick, Md. 21701		25e. REC'D BY REGISTRAR NOV 22 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

66161

36002

1000 JGM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and file any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15633

CERTIFICATE OF DEATH

15636

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 should write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

304 Rockwell Terrace

**3. NAME OF DECEASED
(Type or print)**

First
Virginia

Middle
Lane

Last
Gambrill

5. SEX

Female

6. COLOR OR RACE
White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Hagerstown, Maryland

U. S. A.

13. FATHER'S NAME

William Preston Lane, Sr.

14. MOTHER'S MAIDEN NAME

Virginia Cartwright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

213 48 8005 James H. Gambrill, III (Same as item # 2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Heart Coronary Thrombosis
Arteriosclerotic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

6 weeks

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING

CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

19. WAS AUTOPSY PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 3 1966, to Nov. 16, 1966, that (I) (we) last saw the deceased alive on Nov. 15 1966, and that death occurred at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE

A. Austin Pearre, Sr. M.D.

22b. DATE

SIGNED
November 16, 1966

22c. PHYSICIAN'S NAME (Type)

A. Austin Pearre, Sr. M.D.

ATTENDING
PHYS.

MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

4 E. Church Street, Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 18, 1966

23c. NAME OF CEMETERY OR CREMATORIAL

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Donald W. Addley
M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

NOV 18 1966

Charles Judge

19030

12233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15634

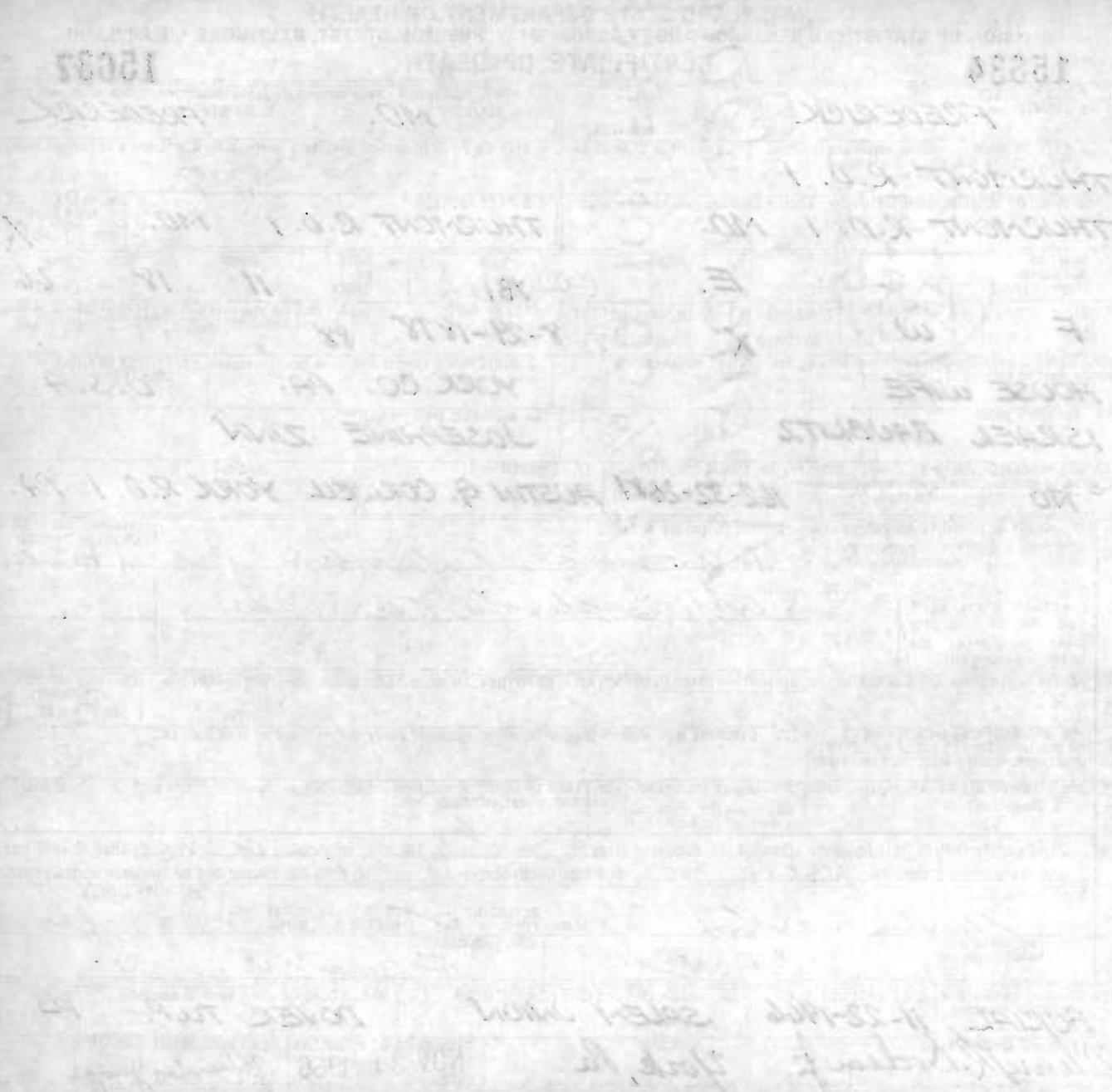
CERTIFICATE OF DEATH

15637

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE M.D. b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THURMONT R.D. 1		c. LENGTH OF STAY IN 1b THURMONT R.D. 1 M.D.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) THURMONT R.D. 1 M.D.		d. STREET ADDRESS THURMONT R.D. 1 M.D.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First IDA	Middle E.	Last GRABILL
4. DATE OF DEATH 11 18 1966	Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1878
9. AGE (in years last birthday) 88 yrs.	10. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	11. BIRTHPLACE (County & State, or foreign country) YORK CO. PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ISRAEL BAUBLITZ	14. MOTHER'S MAIDEN NAME JOSEPHINE ZINN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO 162-32-2681		17. INFORMANT AUSTIN G. CORWELL	Address YORK R.D. 1 PA.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Dis DUE TO (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 18 , 1966, that (I) (we) last saw the deceased alive on Nov 18 , 1966, and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Norman E. Stone	22b. DATE SIGNED 11-19-66		
22c. PHYSICIAN'S NAME (Type) Thomas STONE	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS Frederick, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-22-1966	23c. NAME OF CEMETERY OR CREMATORIAL UNION SALENT UNION	23d. LOCATION (City, town or county) (State) DOVER Twp. PA.
24. FUNERAL DIRECTOR Henry R. Dodson Jr.	ADDRESS York, Pa.	25a. REC'D BY REGISTRAR NOV 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

1535

1535



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15635

CERTIFICATE OF DEATH

15638

1. PLACE OF DEATH e. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 5		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
3. NAME OF DECEASED (Type or print) Evelyn R. White Grove		d. STREET ADDRESS Route 5	
5. SEX Female White		4. DATE OF DEATH Nov. 12-1966	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 14-1910		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Dey Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Dance Studio	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. White - deceased		14. MOTHER'S MAIDEN NAME Rosalie Lingg - living	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 493-24-5250 17. INFORMANT Mr. Robert K. Grove - Route 5-Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>170X</i> DUE TO <i>Metastatic Carcinoma Liver (with liver coma)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO <i>Adeno-carcinoma (right breast)</i>		6 months	
} (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 25, 1966</i> to <i>Nov. 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 12, 1966</i> , and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED Nov. 12-66	
22e. SIGNATURE <i>B.O. Thomas Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. B.O.Thomas-Jr.		22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17-1966 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Elwood T. Whitmore</i> M.R.Etchison & Son		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 17 1966 <i>Charles Judge</i>	

18061

18061



18061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15636

CERTIFICATE OF DEATH

15639

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 13 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hosp				d. STREET ADDRESS 23 W. All Saints Street					
3. NAME OF DECEASED (Type or print) Sylvester Ambrose Gwynn		First	Middle	Last	4. DATE OF DEATH Nov 14 1966	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27, 1906	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger Ft. Detrick		10b. KIND OF BUSINESS OR INDUSTRY ***		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George R. Gwynn		14. MOTHER'S MAIDEN NAME Cornelia Fletcher		Address Frederick, Md					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW 11 219-14-9422		17. INFORMANT Ida N. Gwynn		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Congestive Heart Failure			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 491X		DUE TO (b) Bronchopneumonia	DUE TO (c) Etiologic Agent to be determined	INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Rheumatic Heart Disease		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1966 , to Nov. 14, 1966 , that (I) (we) last saw the deceased alive on Nov. 13, 1966 , and that death occurred at 6:25 AM , from the causes and on the date stated above.		22b. DATE SIGNED 11/14/66							
22a. SIGNATURE Richard C. Reynolds		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave Frederick, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/66		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Church		23d. LOCATION (City, town or county) (State) Petersville, Fred Co. Md			
24. FUNERAL DIRECTOR C.E. Hicks, III		ADDRESS		25a. REC'D BY REGISTRAR NOV 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
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VR A15 (4) 15M 4-64									

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Food Safety and Quality

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10. *Leucosia* *leucostoma* *leucostoma*

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2. *Chlorophytum comosum* L. (Liliaceae) (Fig. 2)

• 102 •

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in ~~part I~~ in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with farm PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

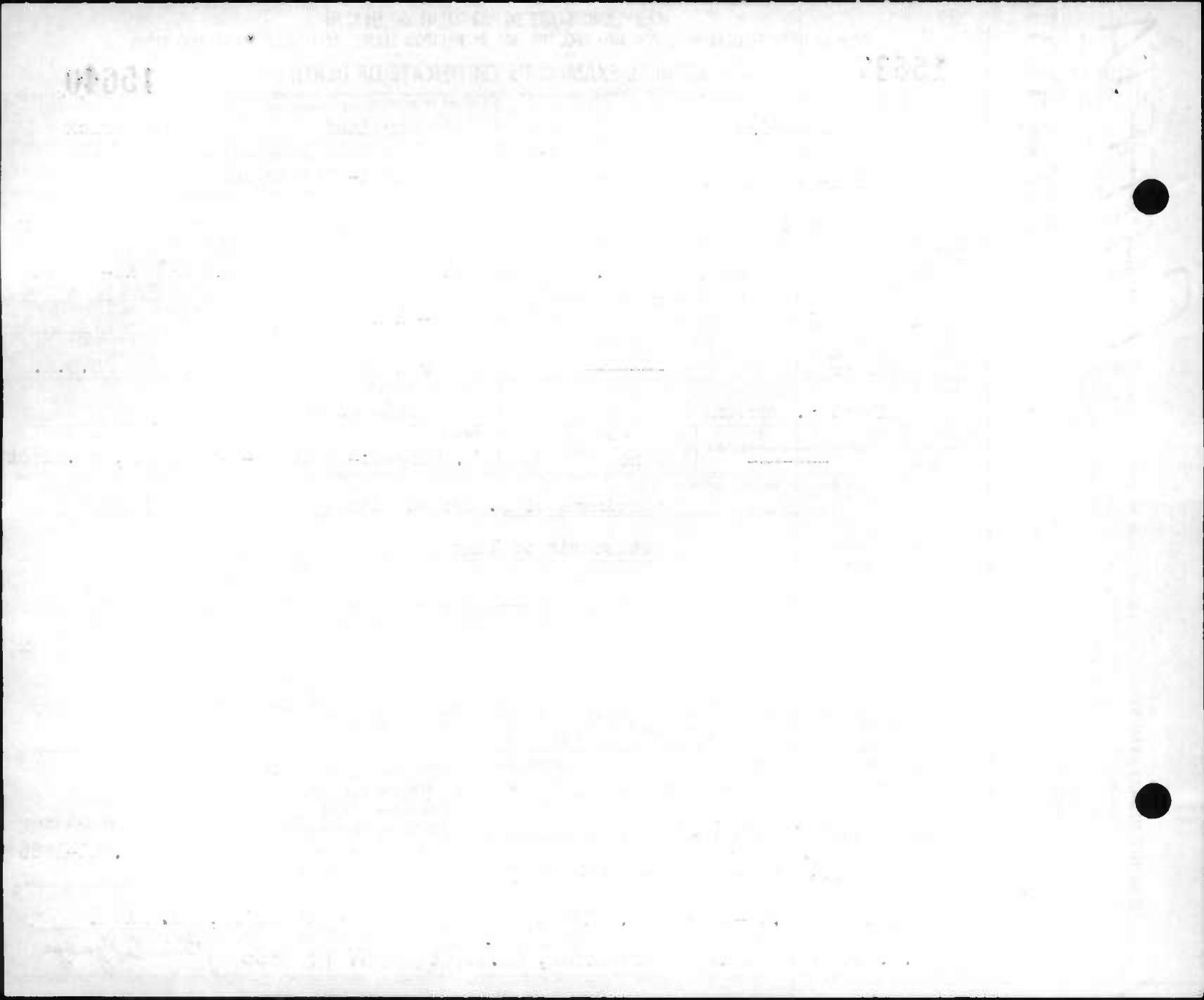
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15640

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 6		d. STREET ADDRESS Route 6	
3. NAME OF DECEASED (Type or print) Mabel		First T.	Middle Hargett
4. DATE OF DEATH November 10- 19 66	Month November	Day 10-	Year 19 66
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH June 4- 1914
9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 52	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert S. Morgan		14. MOTHER'S MAIDEN NAME Katie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Hugh D. Hargett- Route 6- Frederick, Md.21701
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. Metastasis to lung			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) -----		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) B.O. Thomas, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
22. DATE SIGNED Nov. 11-1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov.14-1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City or Town) Frederick, Md. 21701		(County) (State)	
24. FUNERAL DIRECTOR <i>Elwood T.</i> M.R.Etchison & Son		ADDRESS <i>Whitmore</i> Frederick, Md.21701	25a. REC'D BY REGISTRAR DATE NOV 15 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			15641		
1. PLACE OF DEATH a. COUNTY Fr ederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 1 day						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick						10.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital						d. STREET ADDRESS Route XXX # 4						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY KATHRYN HEINE			First	Middle	Last	4. DATE OF DEATH November 29, 1966			Month	Day	Year	XXXX	29	19	66		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 29, 1966			9. AGE (in years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 15		IF UNDER 24 HRS Hours 1 Min. 15				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edwa rd Joseph Heine						14. MOTHER'S MAIDEN NAME Mary Kathryn Wilder						Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH								
No			None			Mother			in 15m								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												respiratory center failure immaturity 21 wks preancy					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from 11/29/66 to 11/29/66 , that (I) (we) last saw the deceased alive on 11/29/66 , and that death occurred at 1145PM , from the causes and on the date stated above.			22b. DATE SIGNED 11/30/66														
22a. SIGNATURE Harry W Gray			22b. ADDRESS Frederick, Maryland			M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) Dr. Harry W. Gray			23. NAME OF CEMETERY OR CREMATORIAL St. Josephs Catholic Cemetery			23d. LOCATION (City, town or county) Carrolton Manor			Fred. Co. Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-30-1966			23c. ADDRESS Frederick, Maryland			23d. REC'D BY REGISTRAR DEC 1 1966				25b. REGISTRAR'S SIGNATURE John J. Dailey				
24. FUNERAL DIRECTOR Robert E. Dailey & Son			25a. DATE 6-216832			25b. REGISTRAR'S SIGNATURE John J. Dailey											

1981

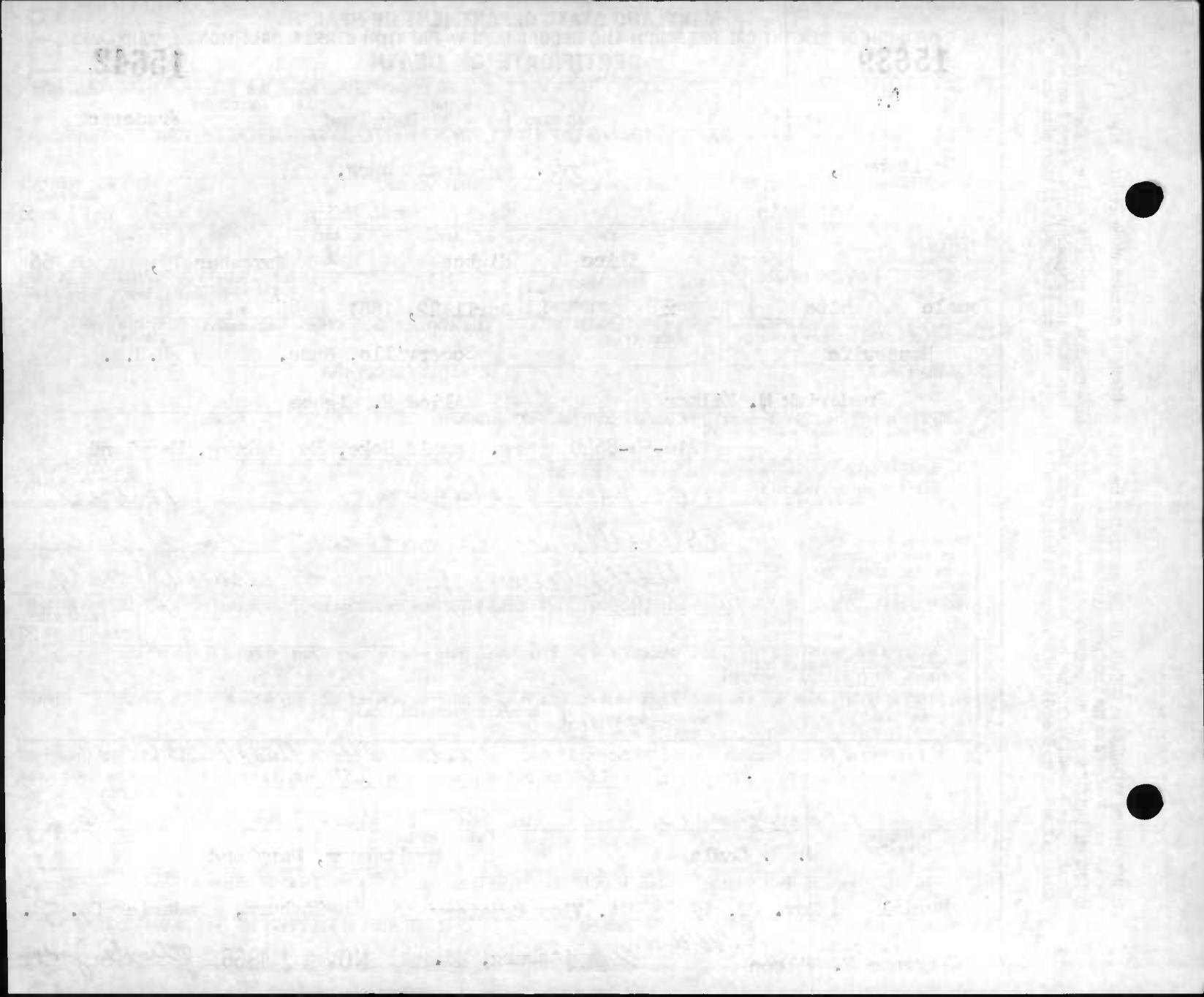
1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		15642			
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE											
Frederick MARYLAND						Maryland						Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?					
Emmitsburg,			59 yrs.			Emmitsburg,			West Main			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)																	
West Main																	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
Female		Mary		Alice		Higbee		November 19,		19		66					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.					
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		April 22, 1881		85 yrs.		Months		Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Housewife								Somerville, Mass.				U.S.A.					
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME					
Frederick M. Kilmer												Alice F. Higbee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
NO				216-54-8640				Mrs. Harold Hoke, Emmitsburg, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion -</i>												1 hour					
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												<i>arteries arteriosclerotic disease - several years</i>					
DUE TO (b) <i>arteries arteriosclerotic disease - several years</i>																	
DUE TO (c) <i>Hypertension -</i>												<i>- several years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1940</i> , to <i>Nov 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 15 1966</i> , and that death occurred at <i>Emmitsburg, Md.</i> from the causes and on the date stated above.																	
22a. SIGNATURE <i>W. R. Cadle</i>						22b. DATE SIGNED <i>11/20/66</i>											
22c. PHYSICIAN'S NAME (Type) W. R. Cadle						22d. ADDRESS Emmitsburg, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Nov. 22, 1966</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. View Cemetery</i>			23d. LOCATION (City, town or county) <i>Emmitsburg, Frederick Co. Md.</i>			(State)					
24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i>						ADDRESS <i>Emmitsburg, Md.</i>						25a. REC'D BY REGISTRAR <i>NOV 22 1966</i>		25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 15M 4-64												DATE					



1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15643

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Years	b. COUNTY Frederick	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 605 North Market Street		d. STREET ADDRESS 605 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First NATHAN	Middle OWEN	4. DATE OF DEATH Month November
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 12, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 57 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Meadow Storage Co.		11. BIRTHPLACE (State or foreign country) Barkhill, Maryland	
13. FATHER'S NAME Nathan O.Hollenbaugh, Jr.		14. MOTHER'S MAIDEN NAME Lillian Keefer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. # 2 220 07 7614	
17. INFORMANT Roger Hollenbaugh, 180 Longview Ave.		Address Westminister, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c) Arteriosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED Nov. 21, 1966
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR <i>Donald M. Fadley</i> M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR DATE NOV 22 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

6100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to cremation, or meno, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
15641						13644							
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 5 weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Co. Emergency Hosp.						d. STREET ADDRESS 401 W. Potomac St.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Maurice Lawson House			First	Middle	Last	4. DATE OF DEATH Nov 5 1966	Month	Day	Year				
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/80	9. AGE (In years last, birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman			10b. KIND OF BUSINESS OR INDUSTRY Railroad			11. BIRTHPLACE (County & State, or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawson House						14. MOTHER'S MAIDEN NAME Margaret Christina Lenhart							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Shannon Langley-Brunswick, Md.						Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						Myocardial infarction Arterosclerotic cardiovascular DUE TO INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 years,						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
19													
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1966, to Oct 3, 1966, that (I) (we) last saw the deceased alive on Oct 5, 1966, and that death occurred at 1 P.M. from the causes and on the date stated above.													
22a. SIGNATURE LeRoy T. Davis						22b. DATE SIGNED 11/7/66							
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis			22d. ADDRESS Frederick, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/8/66			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Union Cemetery			23d. LOCATION (City, town or county) Lovettsville, Va.			(State)	
24. FUNERAL DIRECTOR Tate Funeral Home									25a. REC'D BY REGISTRAR DATE NOV 9 1966			25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15642

15645

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 100 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS WALKERSVILLE	
f. DATE OF DEATH NOV 17 1966		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE HENRY HUFFMAN		First G	Middle H
4. DATE OF DEATH NOV 17 1966		Last H	Month NOV
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 31, 1906		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W HUFFMAN		14. MOTHER'S MAIDEN NAME ETTA EYLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-34-2285	
17. INFORMANT MILDRED HUFFMAN		Address WALKERSVILLE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral hemorrhage		1 day	
DUE TO 44BX		12 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, least. (b)		100 years	
DUE TO (c)		Cerebral thrombosis - left hemiplegia & dysphagia & mutismaphonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Old cerebrovascular accident & residual right hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on and that death occurred at from the causes and on the date stated above.		22b. DATE SIGNED 11/17/66	
22a. SIGNATURE James E. Stoner Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JAMES E. STONER, JR.		22d. ADDRESS WALKERSVILLE, MD	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BURIAL 11/19/66		23c. NAME OF CEMETERY OR CREMATORIAL MT HOPE	
23d. LOCATION (City, town or county) WOODSBORO		(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Lowell Hartzer Woodsboro, Md		25a. REC'D BY REGISTRAR DATE NOV 21 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

19021

19021

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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1 M
C

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										15646									
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)														
a. COUNTY					a. STATE		b. COUNTY												
Frederick		MARYLAND			Maryland		Frederick												
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Frederick					Life					Frederick									
d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM?									
167 West All Saints St					167 West All Saints St					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year										
Derrick		Anthony	Jackson		Nov	20	19	66											
5. SEX		6. COLOR DR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS								
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-26-1966		yrs.	1	24	Months	Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS DR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
None					*****					Frederick Co., Md					U.S.A.				
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
Jessie White										Doris E. Jackson									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)										16. SOCIAL SECURITY NO.					17. INFORMANT				
No *****										None					Doris E. Jackson 167 W. All Saints St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										Address Frederick, Md									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X										INTERVAL BETWEEN DEATH AND DISEASE 7 days									
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO Underlying cause last. (c)										Influenza									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)					
p.m.																			
21. I certify that (I) (this hospital) attended the deceased from 11-18-1966 to 11-20-1966, that (I) (we) last saw the deceased alive on 11-18-1966, and that death occurred at 7 AM, from the causes and on the date stated above.										22b. DATE SIGNED									
22a. SIGNATURE Rex Martin										22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					23d. LOCATION (City, town or county) (State)									
Rex Martin					220 N. Market Street Frederick, Md					Frederick Co. Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county) (State)									
Burial					11-21-66		Fairview			Frederick Co. Md									
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
C.E. Hicks, 111 Frederick, Md										NOV 23 1966					Charles Judge				
6-216-281																			

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Volume 1

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HISTOGRAM

Answers

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19. *Leucosia* *leucostoma* *leucostoma*

The string for the river

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Page 3

46

ANSWER

Journal of Oral Rehabilitation

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1966-67 * 219

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6. What is the total cost?

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15644

CERTIFICATE OF DEATH

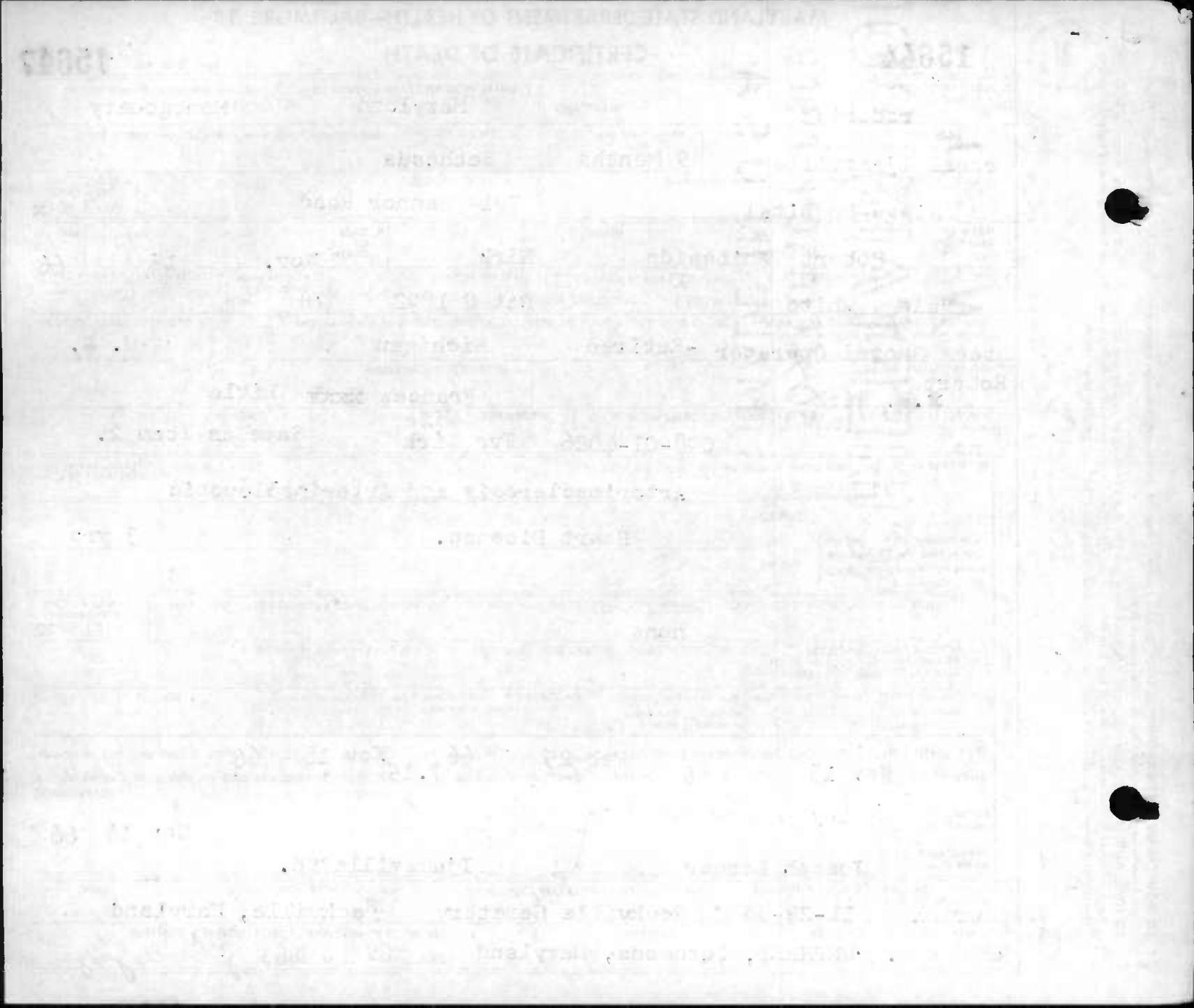
Reg. Dist. No.

15647

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Ijamsville		c. LENGTH OF STAY IN 1b 9 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital		d. STREET ADDRESS 7914 Radnor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert Whiteside	Middle Kirk	Last Nov.	Month 18	Day 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct 8 1892	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Shovel Operator -Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Robert R.W. Kirk		14. MOTHER'S MAIDEN NAME Frances Maxx Little		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 098-01-4026		INFORMANT Wife Eva Kirk Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis and Arteriosclerotic INTERVAL BETWEEN ONSET AND DEATH 4500					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. Heart Disease.		DUE TO Heart Disease.		3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) none					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year 66	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Nov 18		(County) 1966	(State)
21. I certify that I attended the deceased from Feb 25 , 19 66 to Nov 18 , 19 66 that I last saw the deceased alive on Nov 18 , 19 66 , and that death occurred at 7.15 M, from the causes and on the date stated above. p ADDRESS (Street, city or town, state) Joseph Lerner M.D. DATE SIGNED Nov 18 66					
ACTUAL SIGNATURE <i>Joseph Lerner</i>	PHYSICIAN'S NAME (Type) Joseph Lerner				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE NOV 23 1966	
				24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, one funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

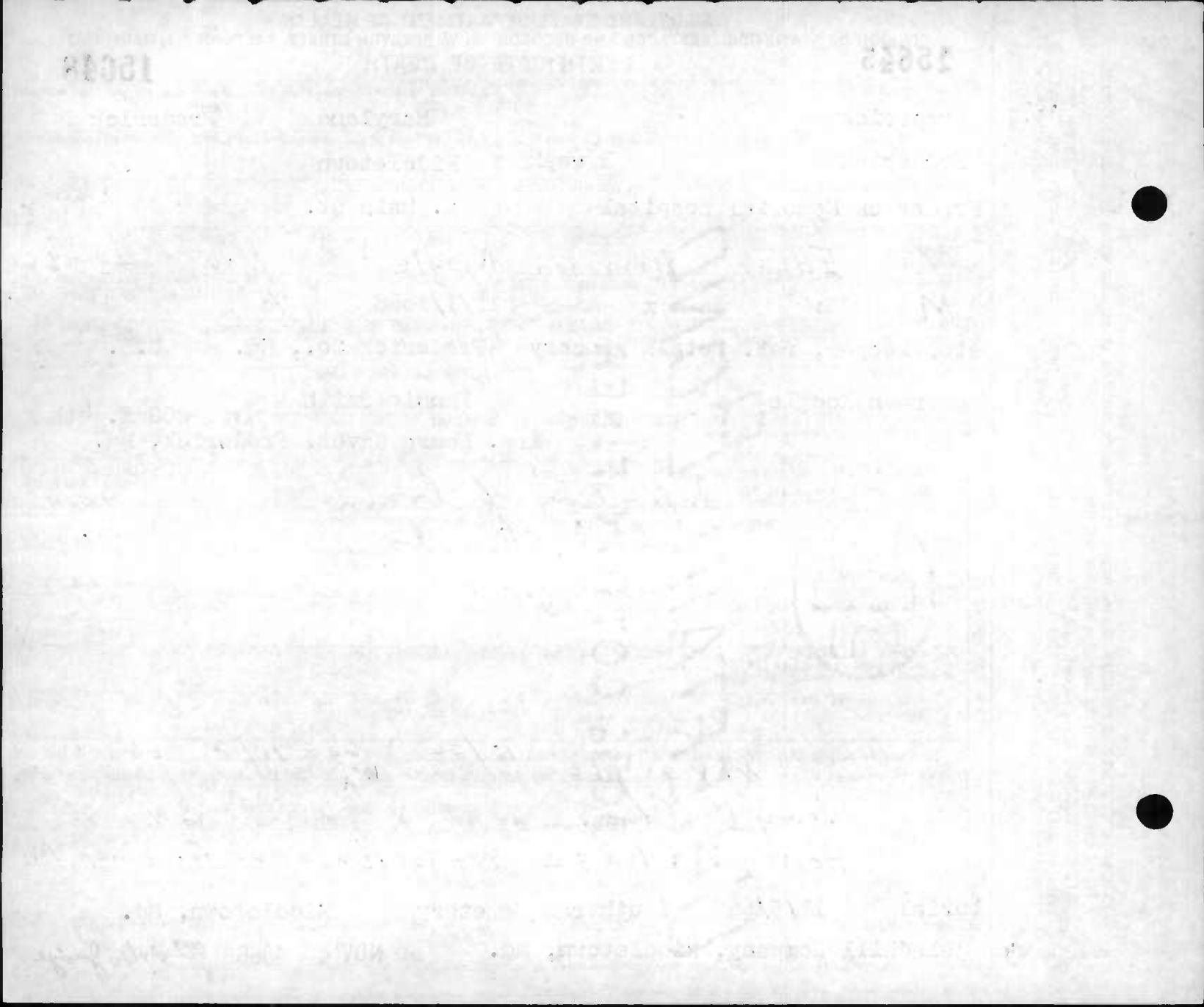
Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15648

1. PLACE OF DEATH a. COUNTY Frederick	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	d. STREET ADDRESS W. Main St.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edgar	Middle Harrison	Last Koogle
4. DATE OF DEATH Month Nov	Day 2	Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) storekeeper, ret. retail grocery		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sherman Koogle	14. MOTHER'S MAIDEN NAME Fannie Smith	Address 200 E. 4th	
15. WAS DEC EASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Laura Gaver, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of brain			
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis			
DUE TO (c) Generalized arteriosclerosis			
DUE TO INTERVAL BETWEEN ONSET AND DEATH 9 days			
9 days			
years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/24 , 19 66 , to 11/2 , 19 66 , that (I) (we) last saw the deceased alive on Nov 2 19 66 , and that death occurred at 10 45 A.M. from the causes and on the date stated above.		22a. SIGNATURE Henry V. Chase	22b. DATE SIGNED 2 Nov 66
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		M.D. <input type="checkbox"/> ATTENDING PHYS. Henry V. Chase	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 804 Toll House Ave Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery	23d. LOCATION (City, town or county) (State) Middletown, Md.
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.	ADDRESS	25a. REC'D BY REGISTRAR NOV 4 1966	25b. REGISTRAR'S SIGNATURE J Charles Judge
VR A15 (4) 20M 1/65			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15646

CERTIFICATE OF DEATH
15649

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
FREDERICK MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
R.FREDERICK	11	RURAL #1 Middletown 101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
Frederick Memorial Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First KANDY	Middle KAY
4. DATE OF DEATH		Last LAKE	Month Nov. Day 2 Year 1966
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MR. Henry Lawrence LAKE		14. MOTHER'S MAIDEN NAME Fahnestock, Carolyn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Henry L. Lake Route #1, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE SEPTICEMIA 0571 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MENINGOCOCCEMIA, ACUTE DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/>		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 1, 1966, to NOV 2, 1966 that (I) (we) last saw the deceased alive on NOV 2, 1966, and that death occurred at 11 AM, from the causes and on the date stated above.			
22a. SIGNATURE J. Fred Baker		22b. DATE SIGNED 11-2-66	
22c. PHYSICIAN'S NAME (Type) Dr. J. Fred Baker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-1966	
23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE NOV 3 1966		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15647		15651													
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 days													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month	Day	Year			
Philip Richard Lease								Nov 25				1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 12, 1913		9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver-WTA		10b. KIND OF BUSINESS OR INDUSTRY Washington Technology		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William Lease		14. MOTHER'S MAIDEN NAME Edith Kenny		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Martha M. Lease		Address 502 Lincoln St., Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 11/20/1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Atherosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 1966, to 11/25 , 1966, that (I) (we) last saw the deceased alive on 11/25 1966, and that death occurred at SP M, from the causes and on the date stated above.		22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 11-25-66		22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave		23d. LOCATION (City, town or county) Arlington, Virginia		(State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.		23d. LOCATION (City, town or county) Arlington, Virginia		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE j Charles Judge		(State)			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		DATE NOV 30 1966											
VR A15 (4) 15M 4-64															

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15651

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brunswick Md.		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #7		d. STREET ADDRESS Rt. #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BERYLE	Middle LICHTENSTEIN	Last 1XOU
4. DATE OF DEATH	Month 6	Day 19 66	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31, 1908 58
9. AGE (In years last birthday) 58 yrs.	10. KIND OF BUSINESS OR INDUSTRY Social Worker	11. BIRTHPLACE (State or foreign country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME ROSE XAVIER	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT THEODORE LICHTENSTEIN Address Fredrick Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8164			
(b) Lacerated Heart			
DUE TO (c) Fractured Ribs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour 11 p.m. 11-6 1966		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Highway		20f. (City or town) In Brunswick - Frederick (County) MD (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, Sr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF 11-12-66		Address (Street, city, town, or county) RESTHAVEN	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) FREDERICK (County) MD (State)	
24. FUNERAL DIRECTOR SALAMONE FUNERAL HOME		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE	
		DATE NOV 10 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15652

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brunswick</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rt. # 7</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THEODORE</u>		First <u>S.</u>	Middle <u>LICHTENSTEIN</u>
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consultant</u>	9. AGE (In years lost birthday) <u>55 yrs.</u>
13. FATHER'S NAME <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
17. INFORMANT <u>Theodore Lichtenstein, Jr., Fred. Md.</u>		Address <u>Unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull, Saccrated Brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two car collision</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:45</u> p.m. <u>11-6 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>
20f. (City or town) <u>Mr. Brunswick - Fred - Md.</u>		(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O.Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O.Thomas, SR.M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF <u>11-12-66</u>		Address (Street, city, town, or county) <u></u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Resthaven Cem</u>		23d. LOCATION (City or Town) <u>Frederick</u>	
24. FUNERAL DIRECTOR <u>SALAMONE FUNERAL HOME</u>		(County) <u>Fred. Md.</u>	
ADDRESS <u>FREDERICK, MD</u>		(State) <u></u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 10 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15650						15653					
1. PLACE OF DEATH a. COUNTY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
Frederick			MARYLAND			e. STATE Maryland			b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Frederick			years			Frederick			Formerly- 22 W. South St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Wynelle Nursing Home			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Ollie Vitta Lipps						November	28	19	66		
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	85 yrs.				
Female White			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 23-1881	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	Frederick County Md.	U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	Sarah E. Burrier	Address	Md.			
Homemaker				Frederick County Md.	U. S. A.						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or date of service)			16. SOCIAL SECURITY NO. 17. INFORMANT		
Charles O. Phebus			Sarah E. Burrier			No			219- 20- 2280 Laurens N. Bowers- 113 E. 7th. St.-Frederick		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH		
331X						Cerebral Hemorrhage			3 days		
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.						(b) Generalized arterio-sclerosis			10 years		
} DUE TO						(c) N					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Diabetes											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
p.m.											
21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1961, to Nov. 28, 1961, that (I) (we) last saw the deceased alive on Nov. 28, 1961, and that death occurred at 11:15a.m. from the causes and on the date stated above.											
22a. SIGNATURE Bernard O. Thomas Jr.			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas Jr.						22d. ADDRESS Professional Bldg.- Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 1-1966			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION (City, town or county) (State) Frederick, Md. 21701		
24 FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son			ADDRESS Whitmore Frederick, Md. 21701			25a. REC'D BY REGISTRAR DEC 1 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. On any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15651

CERTIFICATE OF DEATH

15654

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dickerson - Rural</i>		d. STREET ADDRESS <i>Frederick Nursing & Convalescent Center</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Nursing & Convalescent Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH Month <i>Nov.</i>		Day Year <i>11 1966</i>	
3. NAME OF DECEASED (Type or print)	First <i>Eleanor</i>	Middle <i>D.</i>	Last <i>Lonie</i>	4. DATE OF DEATH Month <i>Nov.</i>	Month <i>Nov.</i>	Day <i>11</i>	Year <i>1966</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <i>Widowed</i>	NEVER MARRIED DIVORCED <i>Divorced</i>	8. DATE OF BIRTH <i>March 16-1896</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days Hours Min. <i>0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housing</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Sereno Waring</i>	14. MOTHER'S MAIDEN NAME <i>Sullivan Collier</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>058-01-9090</i>		
17. INFORMANT <i>Maryfield Lonie, Dickerson, Md.</i>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Heart Disease</i>		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>804 Toll House Ave Frederick, Md</i>		20f. (City or town) (County) (State) <i>Frederick, Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 6, 1966</i> , to <i>Nov 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 10, 1966</i> , and that death occurred at <i>7:40 AM</i> , from causes and on the date stated above.						22b. DATE SIGNED <i>11 Nov 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		22d. ADDRESS <i>804 Toll House Ave Frederick, Md</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23o. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Valley</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick, Md</i>	
24. FUNERAL DIRECTOR <i>William B. Hilton, Barnesville, Md.</i>		ADDRESS <i>1114166</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 16 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2001

1970-10-30 00000000

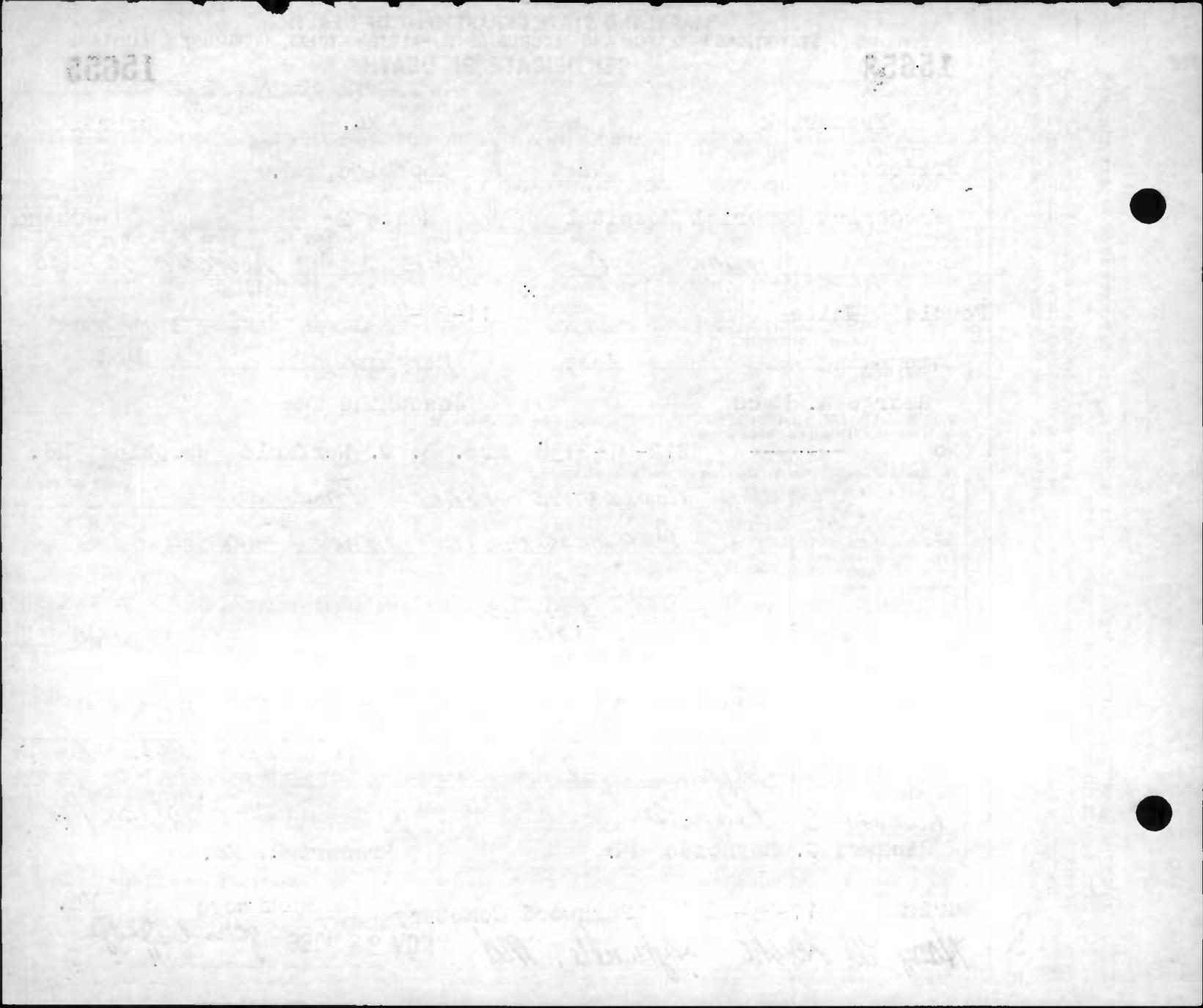
2001

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2018 BY SP/SP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY Frederick MARYLAND				a. STATE Md. b. COUNTY Carroll											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick week				c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine, Md. 86-2											
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
				Route 2											
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
LILLIAN				C	MACE		NOVEMBER 22			1966					
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Female		White					11-28-80	85 yrs.	Months	Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaking				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George A. Mace 14. MOTHER'S MAIDEN NAME Josephine Tubman															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT				Address Mrs. B. D. Warfield Woodbine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Anemia - Pancytopenia Aplastic												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) this hospital attended the deceased from 11/21 , 19 66 , to 11/22 , 19 66 , that (I) last saw the deceased alive on 11/22 19 66 , and that death occurred at 11 PM , from the causes and on the date stated above.				22b. DATE SIGNED 11/22/66											
22a. SIGNATURE Richard C. Reynolds				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS Frederick, Md.							
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds MD				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-25-66 23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery 23d. LOCATION (City, town or county) (State) Baltimore Md.											
24. FUNERAL DIRECTOR Kerry W. Bright				ADDRESS Sykesville, Md.				25a. REC'D BY REGISTRAR NOV 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge							



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15654

CERTIFICATE OF DEATH

15656

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nr. Urbana - Rural		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Urbana	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route # 1, Ijamsville		d. STREET ADDRESS Route # 1, Ijamsville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUTH		First	Middle
4. DATE OF DEATH November 3 1966		Month	Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 12, 1903		9. AGE (in years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel Tompkins		14. MOTHER'S MAIDEN NAME Jennie Richmond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) No		16. SOCIAL SECURITY NO. 367 24 5534	17. INFORMANT Norman B. McFadyen (Same as item # 2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 11 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-14- , 19 56 to 11-3- , 19 66 , that (I) (we) last saw the deceased alive on Aug. 5, 1966 , and that death occurred at 9 A.M. from the causes and on the date stated above.		22b. DATE SIGNED Nov. 4, 1966	
22e. SIGNATURE Rex R. Martin		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.		22d. ADDRESS 220 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Gardens
23d. LOCATION (City, town or county) Hansonville, Maryland		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE Donald W. Faddley		25a. REC'D BY REGISTRAR NOV 10 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A1S (4) 20M 5-63		DATE	

10001

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10001

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15655

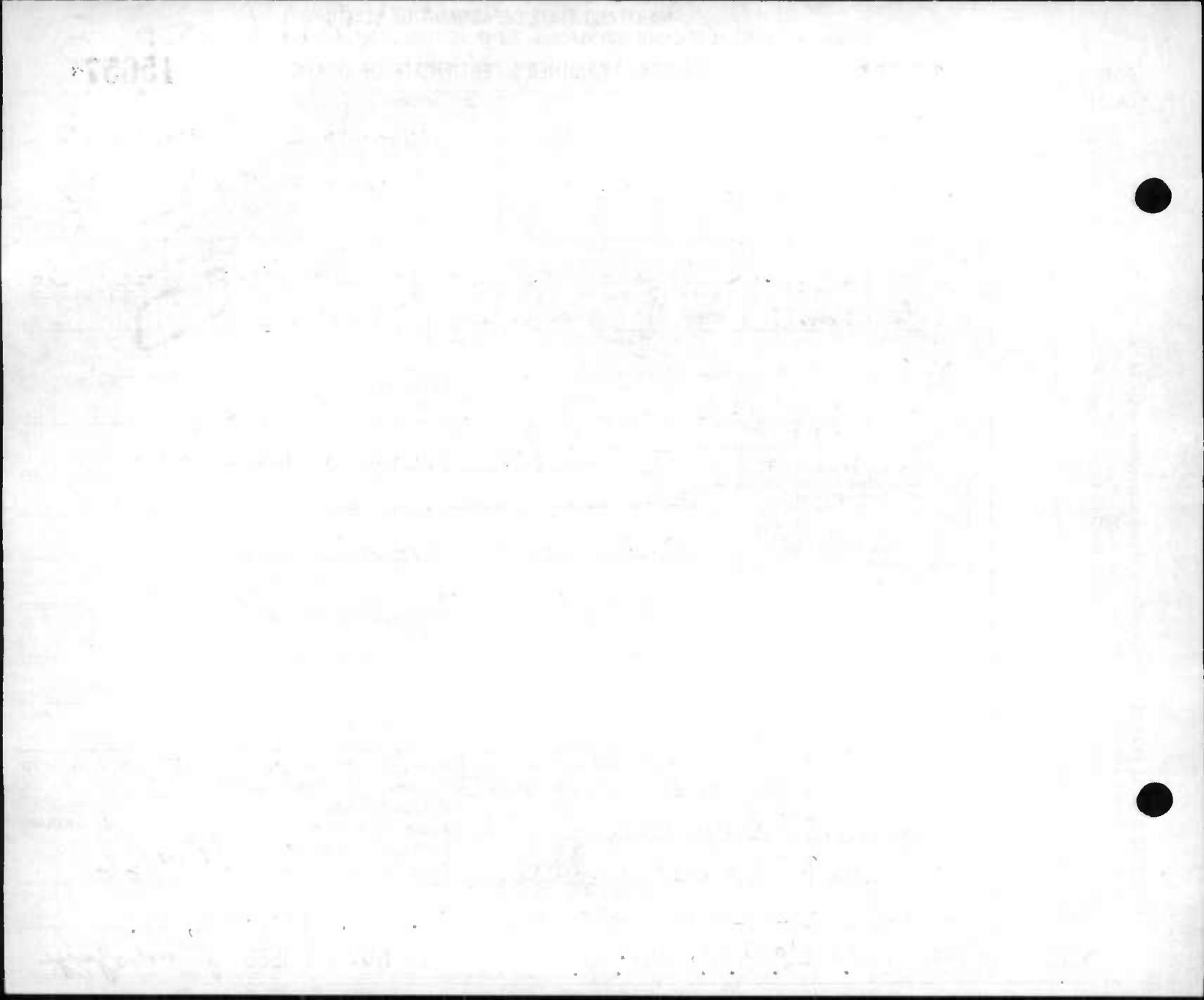
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15657

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Knoxville R.D.T.</i>	c. LENGTH OF STAY IN 1b <i>15 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Knoxville R.D.T.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>James Marshall McHugh</i>		First <i>J</i>	Middle <i>M</i>
4. DATE OF DEATH <i>November 7 1966</i>	Month <i>Nov</i>	Day <i>7</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>12/27/1899</i>
9. AGE (In years last birthday) <i>66 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Marine Colonel</i>	11. KIND OF BUSINESS OR INDUSTRY <i></i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Austin McHugh</i>	14. MOTHER'S MAIDEN NAME <i>Lutie Lindsey</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes 1941-42</i>	
16. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>Mr. Maurice McHugh</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4701 Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arterosclerotic Heart Disease</i> DUE TO stating the underlying cause (c) <i>Hypertension</i> DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		
EXAMINER'S NAME (Type) <i>B.O. Thomas, M.D.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>11749/86</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-10-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l. Cem. Arlington, Va.</i>	23d. LOCATION (City or Town) (County) (State) <i>(County) (State)</i>
24. FUNERAL DIRECTOR <i>Joseph Gowler's Sons, Inc.</i>	ADDRESS <i>5130 Wisconsin Ave. N.W. Washington, DC.</i>	25a. RECD BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15656					CERTIFICATE OF DEATH					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY Frederick MARYLAND					a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7					
c. LENGTH OF STAY IN 1b 5 Yrs.					d. STREET ADDRESS Yellow Springs					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALICE First LIGHTBOWN Middle MC MANEMON Last					4. DATE OF DEATH Month Day Year November 12, 1966					
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					Months Days Hours Min.					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 22 June 1919 47 yrs.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work					10b. KIND OF BUSINESS OR INDUSTRY Own Home					
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.					12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Chester Lightbown					14. MOTHER'S MAIDEN NAME Marie (Last name unknown)					
15. WAS DEC EASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 17. INFORMANT Address 222 03 6189 William E. McManemon (Same as item #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					Selma, Alabama 9 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> , 19 <u>66</u> , to <u>Nov 12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> 19 <u>66</u> , and that death occurred at <u>3:50</u> A.M. from the causes and on the date stated above.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
22a. SIGNATURE <u>Thomas E. Stone</u>					22b. DATE SIGNED <u>11-12-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Stone</u>					22d. ADDRESS <u>Frederick, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>					23b. DATE THEREOF <u>11/14/66</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Md.</u>					ADDRESS <u>21701</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
20M 1/65					DATE					

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(SEARCHED INDEXED) DOCUMENTS RECEIVED FROM AGENTS

1948

NOTICE OF RECEIPT AND INDEXING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15657

CERTIFICATE OF DEATH

15659

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Minutes		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				
3. NAME OF DECEASED (Type or print) Raymond C. Miller		First	Middle	Last	4. DATE OF DEATH Nov. 25 1966	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-1903	9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William Henry Miller		14. MOTHER'S MAIDEN NAME Clara Bell Fuss								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-2572		17. INFORMANT Luella M. Miller		Address Thurmont, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 24 hr 420.1 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) atherosclerotic heart disease years (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Thurmont		(County) Md.	(State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25 1966 , to 11/25 1966 , that (I) (we) last saw the deceased alive on 11/25 1966 , and that death occurred at 10:15 AM , from the causes and on the date stated above.										
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 11/25/66								
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave Frederick								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-27-66		23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Com.		23d. LOCATION (City, town or county) Thurmont Fred Co. Md.		(State)		
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR NOV 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 15M 4-64										

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Indicates information solicited

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15658

CERTIFICATE OF DEATH

15660

Item 3, Given name deduced from birth cert. 2/1/67 see

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

Since Birth

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

64
3. NAME OF DECEASED Christina First Marie Middle Last

(Type or print) Baby Girl Monroe

4. DATE OF DEATH

5. SEX

6. COLOR DR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

7544 DUE TO

Conditions, If any, which

gave rise to Immediate

cause (a), stating the

underlying cause last.

(b)

DUE TO

Conditions, If any, which

gave rise to Immediate

cause (a), stating the

underlying cause last.

(c)

FIBROELASTOSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

ASPIRATION

20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

11/18/66

While at work Not While at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Gaithersburg. Md

21. I certify that (I) (this hospital) attended the deceased from 11-15, 1966, to 11-18, 1966, that (I) (we) last

saw the deceased alive on 11-18, 1966, and that death occurred at 2:00 PM, from the causes and on the date stated above.

22a. SIGNATURE

Ernest C. Gartner

22b. DATE SIGNED

11/18/66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

Forest Oak

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

11-20-66

23c. NAME OF CEMETERY OR CREMATORIUM

Forest Oak

23d. LOCATION (City, town or county) (State)

Gaithersburg. Md

24. FUNERAL DIRECTOR

Ernest C. Gartner

ADDRESS

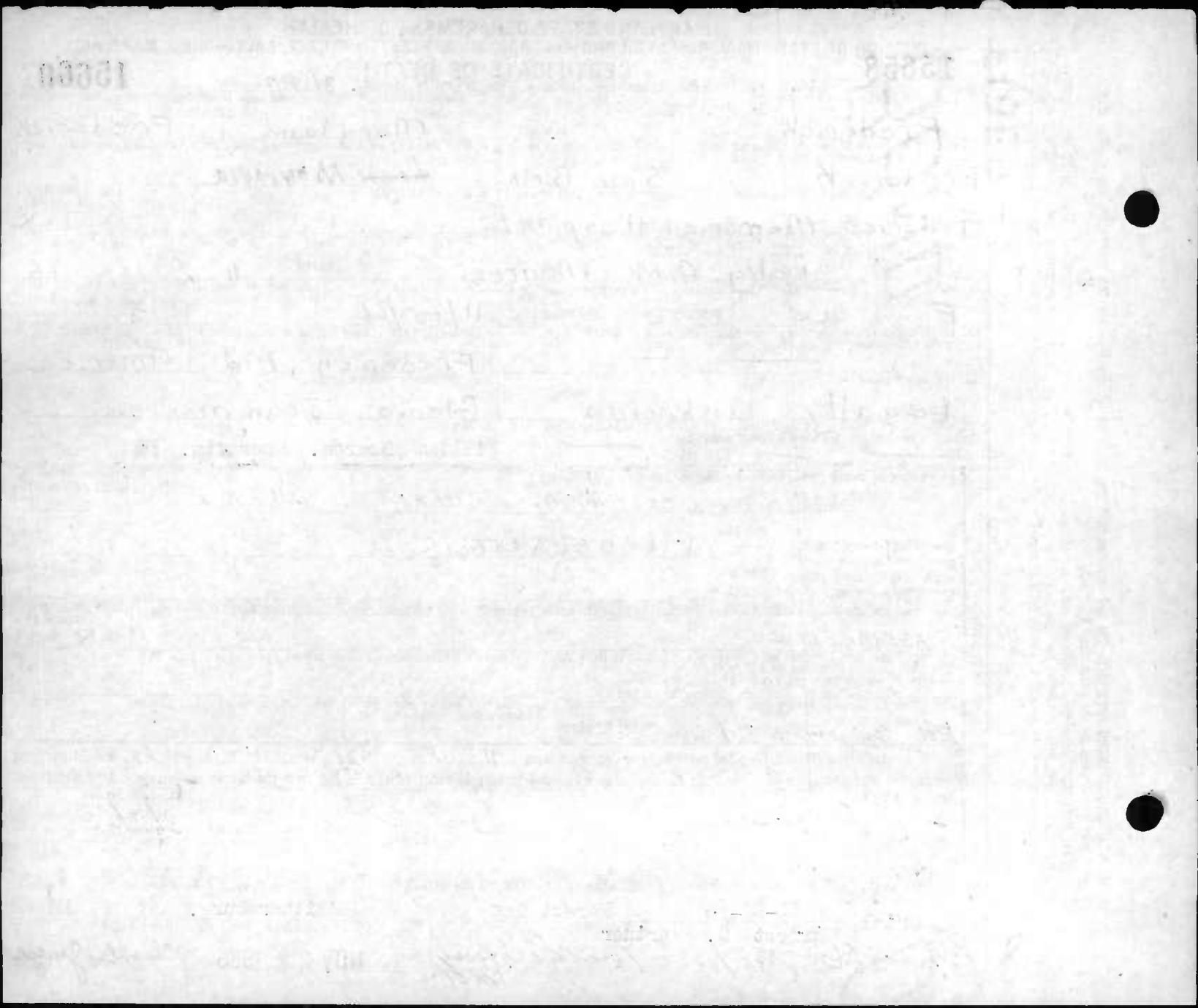
6-216 774

25a. REC'D BY REGISTRAR

NOV 22 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15661
CERTIFICATE OF DEATH												
Item 8 Film 0303 12/3/66												15661
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE										
Frederick		Maryland										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY										
Frederick		Frederick										
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)										
days		Frederick										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS										
Frederick Memorial Hospital		6 Norva Avenue										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First ELSIE	Middle VIOLA	Last NORWOOD	4. DATE OF DEATH	Month November	Day 24,	Year 1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	1894	9. AGE (In years last birthday)	72	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS	13. MIN.	
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 6, 1874	yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Homemaker			None			Montgomery County, Md.			U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
Daniel R. Morningstar					Olive L. Hawes							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			214-24-6309			Mr. Earl E. Norwood			6 Norva Ave. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
450.0 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
MEDICAL CERTIFICATION												
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		11/18, 1966, to 11/24, 1966, that (I) (we) last and that death occurred at 11/24, 1966, M, from the causes and on the date stated above.										
22a. SIGNATURE		22b. DATE SIGNED Robert S. Hughes M.D. 11-24-1966										
22c. PHYSICIAN'S NAME (Type)		Dr. Robert S. Hughes M.D.		22d. ADDRESS		23d. LOCATION (City, town or county)		(State)				
Burial		11-28-1966		Mount Olivet Cemetery		Frederick, Maryland						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Robert E. Dailey & Son		Frederick, Maryland		OAT NOV 28 1966		Charles Judge						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												15662
1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville				b. COUNTY Washington								
c. LENGTH OF STAY IN 1b Minutes				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Black Rock Road				d. STREET ADDRESS								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			First Joann	Middle Virginia	Last Physioc	4. DATE OF DEATH November 24, 1966	Month Day Year	Month Day Year	Month Day Year	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1939	9. AGE (In years last birthday) 27 yrs.	4	9			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer			10b. KIND OF BUSINESS OR INDUSTRY Trucking Industry			11. BIRTHPLACE (State or foreign country) Boonsboro, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles McAllister				14. MOTHER'S MAIDEN NAME Freda Foreman								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. 220-34-0234			17. INFORMANT Mr. Willis J. Physioc III Boonsboro, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9768 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH imed.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> B.O. Thomas M.D.
												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> B.O. Thomas M.D.
												DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 11-29-66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-66		23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 29 1966		25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.						

893

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

15661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15663

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Days		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 201 South Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GRACE	Middle IRENE	Last PONELL
4. DATE OF DEATH November 5, 1966	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH March 17, 1911
8. AGE (In years last birthday) 55 yrs.		9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Frederick, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Zeno Brightwell	
14. MOTHER'S MAIDEN NAME Mary Ellen Hargett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Leroy George Brightwell (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amenia 216X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bilateral Hydronephrosis & Pyelonephritis (c) Bilateral Serous Cysts of Ovaries			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) B.O.Thomas, Sr.M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 8, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS Fedeler	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

canal

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15664					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY Frederick				a. STATE Maryland b. COUNTY Frederick													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Life													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 102 McMurray Street													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. DATE OF DEATH November 15, 1966 Month Day Year													
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH										
				NORA	JANE	RABE	November 15, 1966										
5. SEX				6. COLOR DR RACE		7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH				9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
Female				White		2 Nov 1882				11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
Jacob H. Deter				Georgianna Abrecht													
15. WAS DECEASED EVER IN U.S. ARMED FORCES?				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
(Yes, no, or Unknown) (If yes give war or dates of service)				103 12 3789D				Mrs. Norma E. Bruchey (Same as item #2)									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5102 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.												Congestive Heart Failure days					
DUE TO (b) cause (a), stating the underlying cause last.												Infarcted Small Bowel - Intestinal obstruction hours					
DUE TO (c)												Post operative edema ? years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-14, 1966 to 11-15, 1966, that (I) (we) last saw the deceased alive on 11-15, 1966, and that death occurred at 1:15 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE Robert J. Thomas				22b. DATE SIGNED 16 Nov 1966													
22c. PHYSICIAN'S NAME (Type) Robert J. Thomas, M. D.				22d. ADDRESS 812 Toll House Ave., Frederick, Md.								21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/18/66		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery				23d. LOCATION (City, town or county) (State) Frederick, Md. 21701							
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701				25a. REC'D BY REGISTRAR NOV 18 1966								25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65				DATE													

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15663

CERTIFICATE OF DEATH

15665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libertytown		d. STREET ADDRESS 10-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital							
3. NAME OF DECEASED (Type or print)	First Mary	Middle Magdalene	Last Roberts	4. DATE OF DEATH Nov. 30, 1966	Month Nov.	Day 30	Year 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 12, 1902	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10. KIND OF BUSINESS OR INDUSTRY housekeeper at home		11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Grant Collins		14. MOTHER'S MAIDEN NAME Cynthia Collins		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Neal Roberts, Libertytown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		<i>Hypocardial infection, adult</i>				5 days	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause lost. (b)		<i>Hypertensive arteriosclerotic cardiovascular disease</i>				several years	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, office bldg.	20f. (City or town) Wilmington, Md.	(County) Wicomico Co.	(State) Md.	
19		at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from June 9, 1966 , to Nov. 30, 1966 , that (I) (we) last saw the deceased alive on Nov. 30, 1966 , and that death occurred at 9:27 AM , from the causes and on the date stated above.							
22e. SIGNATURE <i>Ernest A. Dettbarn</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/30/66
22c. PHYSICIAN'S NAME (Type) ERNEST A. DETTBARN		22d. ADDRESS Wilmington, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-4-1966	23c. NAME OF CEMETERY OR CREMATORIAL Tennessee Valley Cem.	23d. LOCATION (City, town or county) Sneadserville, Tenn.	(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Heitler & Sons</i>		ADDRESS Libertytown, Md.	25e. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE		
			DATE DEC 2 1966				

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**FOR STATE
HEALTH DEPT.**

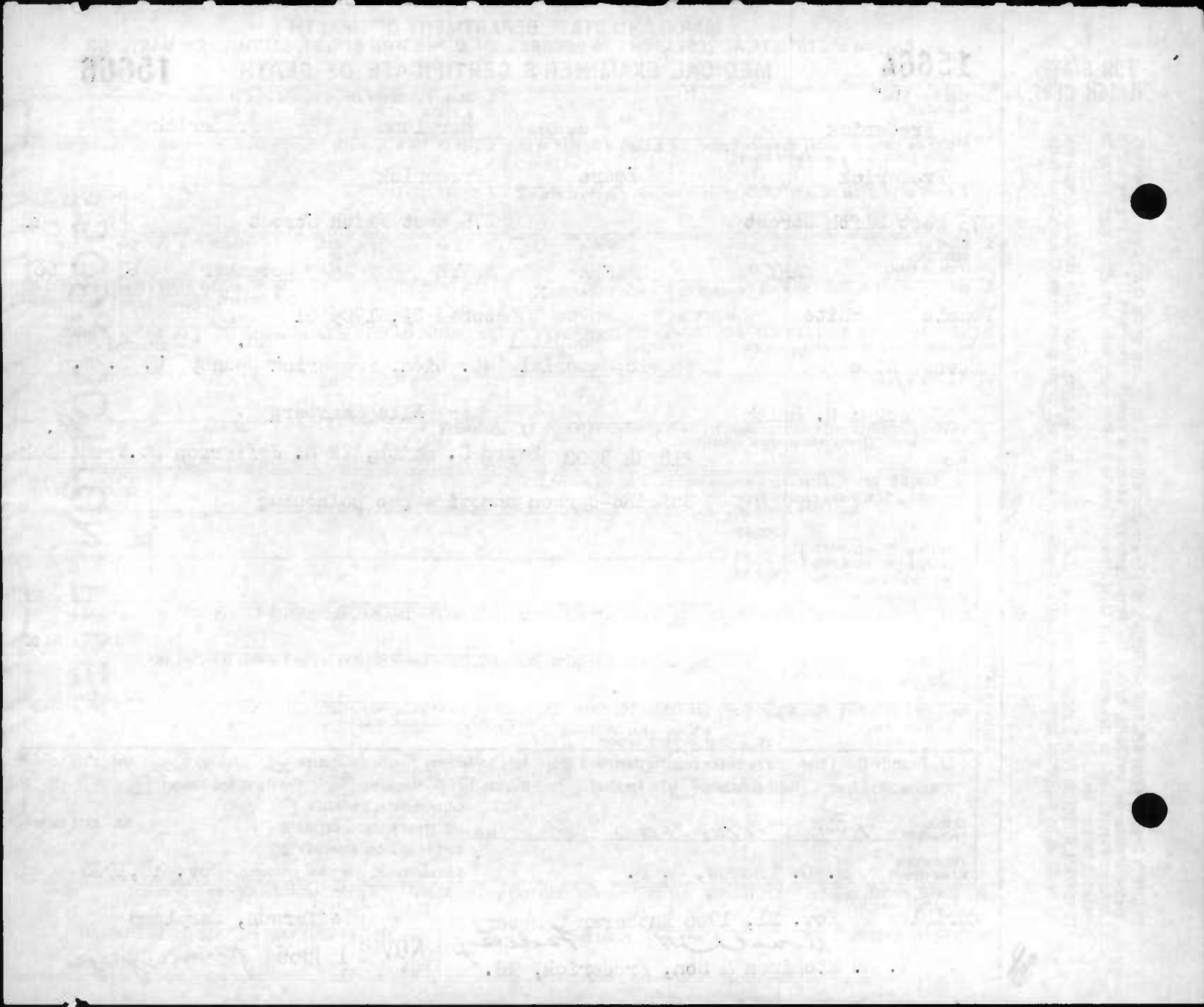
**MARYLAND STATE DEPARTMENT OF HEALTH
STATICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
c. LENGTH OF STAY IN 1b Years			b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 275 West Fifth Street			d. STREET ADDRESS 275 West Fifth Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First HELENA	Middle SMITH	Last NOVEMBER	Month 18
4. DATE OF DEATH 18 19 66		Day 18	Year 1966		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 23, 1905	9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide		10b. KIND OF BUSINESS OR INDUSTRY Hospital Frederick Memorial	11. BIRTHPLACE (State or foreign country) Mt. Zion, Frederick County	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George H. Smith					
14. MOTHER'S MAIDEN NAME Mary Ella Reinsberg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218 34 3900	17. INFORMANT Evard C. Smith, 322 S. Jefferson St. Frederick	Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide—carbon monoxide gas poisoning INTERVAL BETWEEN ONSET AND DEATH 9731					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 		DUE TO (b)	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jefferson	(County) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED B. O. Thomas, M. D.					
ACTUAL SIGNATURE B. O. Thomas					
EXAMINER'S NAME (Type) B. O. Thomas, M. D.					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) Nov. 18, 1966					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	23d. LOCATION (City, town or county) Jefferson, Maryland	(State)
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.		ADDRESS Donald M. Fadley	25a. REC'D BY REGISTRAR NOV 21 1966	25b. REGISTRAR'S SIGNATURE Charles J. George	DATE

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER
please execute the certificate
of director. Page 4 should
be retained for your files.

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15665

CERTIFICATE OF DEATH

15667

1. PLACE OF DEATH a. COUNTY FREDERICK		Item 2 Information from birth cert. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Legore	
						d. STREET ADDRESS 10.1	
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First TERRY	Middle LEN	Last STACKHOUSE	4. DATE OF DEATH Nov 18 1966	Month Nov	Day 18	Year 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WOOED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Nov 66	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 3	Hours Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) Frederick and MD	12. CITIZEN OF WHAT COUNTRY USA
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13. FATHER'S NAME Clifton Monahan	14. MOTHER'S MAIDEN NAME Doris Stackhouse		
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545		
OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Due to (c)		
Congenital heart disease (Type undetermined)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERRYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) **this hospital** attended the deceased from **13 Nov 66**, to **18 Nov 1966**, that (I) (we) last saw the deceased alive on **18 Nov 1966**, and that death occurred at **2:40 PM**, from the causes and on the date stated above.

22a. SIGNATURE
R L Guest

22b. DATE SIGNED
13 Nov 66

22c. PHYSICIAN'S NAME (Type)
RL Guest

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE THEREOF
Nov 26 66

23c. NAME OF CEMETERY OR CREMATORIAL
St. B Cem

23d. LOCATION (City, town or county)
Thurmont Frederick Md

(State)

24. FUNERAL DIRECTOR
RAYMOND E. CREASER

ADDRESS

25a. REC'D BY REGISTRAR
NOV 23 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

5001

5001



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15666

CERTIFICATE OF DEATH

15668

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick two days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route # 3 Frederick 10-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First LAURA	Middle BROWN	Last STALEY	
4. DATE OF DEATH	Month November	Day 17,	Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1907	
9. AGE (In years last birthday) 59 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Charles F. Brown			
14. MOTHER'S MAIDEN NAME Laura R. Summers	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 220-42-7406	17. INFORMANT Mr. Harry C. Staley	Address Rt. # 3 Frederick, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Left Cerebral Dystrophy INTERVAL BETWEEN ONSET AND DEATH 3 days 332 X DUE TO Conditions, If any, which gave rise to Immediate (b) Cerebral Artery Thrombosis 3 11 cause (a), stating the underlying cause last. (c) Cerebral Arteriosclerosis 2 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 1966, to 11-17-1966 , that (I) (we) last saw the deceased alive on 11-17-1966 , and that death occurred at 53 M, from the causes and on the date stated above.	22b. DATE SIGNED 11-17-1966			
22a. SIGNATURE <i>Rex R. Martin</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin	22d. ADDRESS 220 N. Market Street Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-21-1966	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR <i>Robert E. Dailey</i>	ADDRESS Robert E. Dailey & Son Frederick, Maryland	25a. REC'D BY REGISTRAR NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										15667		15669			
CERTIFICATE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					a. STATE		b. COUNTY			
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					c. LENGTH OF STAY IN 1b Rural Emmitsburg, 83 yrs.					Maryland		Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1										R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Martha	Middle Ellen	Last Stouter	4. DATE OF DEATH			Month November	Day 16	Year 1966				
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH			9. AGE (in years last birthday) May 3, 1883 83 yrs.	10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife					Frederick Co. Md.				U.S.A.				
13. FATHER'S NAME Annius Ferguson					14. MOTHER'S MAIDEN NAME Carrie Miller										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 215-20-9304 A					17. INFORMANT Bernard Stouter, Emmitsburg, Md. R.D.#1 Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 4221															
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.					DUE TO (b) Chronic Passive Congestion DUE TO (c) Arteriosclerotic Cardio-Vascular Disease					6 months 60 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from January 1965 , to 16 November 1966 , that (I) (we) last saw the deceased alive on 16 November 1966 , and that death occurred at 11 AM , from the causes and on the date stated above.															
22a. SIGNATURE James H. Hammel MD										22b. DATE SIGNED 11-17-66					
22c. PHYSICIAN'S NAME (Type) James H. Hammel M.D.					22d. ADDRESS Fairfield, Penn 17320										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Nov. 18, 1966			23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic		23d. LOCATION (City, town or county) (State) Emmitsburg, Md. Frederick Co.					
24. FUNERAL DIRECTOR					ADDRESS Clarence E. Wilson					25a. REC'D BY REGISTRAR NOV 18 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

1000



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #N3. Page 5 may be retained for your files.

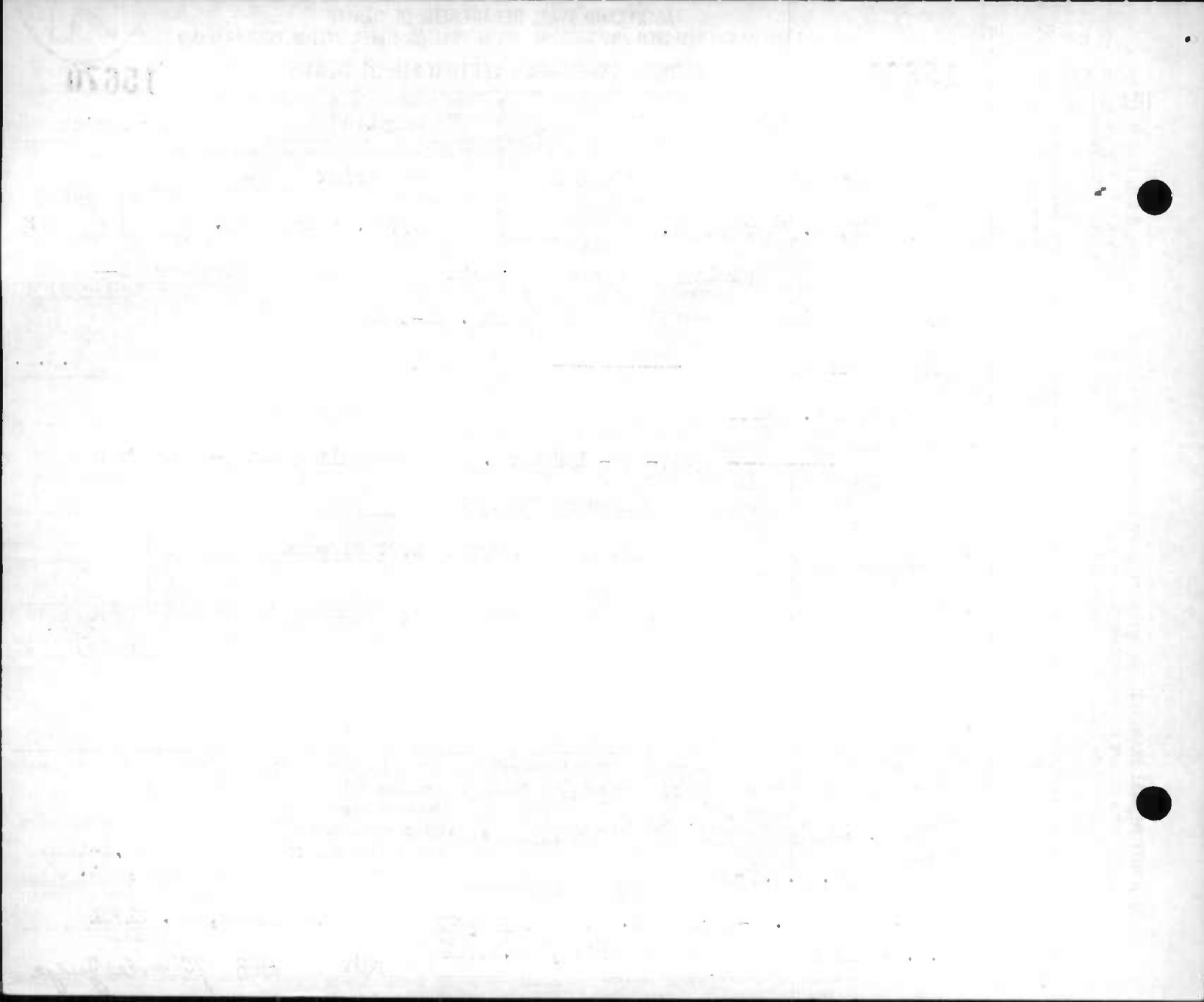
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

15668

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15670

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 277 W. Patrick St.		d. STREET ADDRESS 277 W. Patrick St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Melvin Eugene Stull	First Melvin	Middle Eugene	Last Stull
4. DATE OF DEATH November 1— 1966	Month November	Doy 1	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Aug. 21-1916		9. AGE (In years lost birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch Repairing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Stull		14. MOTHER'S MAIDEN NAME Bernice Watts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-1948	
17. INFORMANT Mrs. Bernice Stull Straley- Same as 2 d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) Arterio sclerotic heart disease			
DUE TO Obese			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) Dr. B.O.Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED Nov. 1-1966			
Address (Street, city, town, or county) Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4-1966	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
23d. LOCATION (City or Town) Frederick, Md.		(County) 21701	
(State)			
24. FUNERAL DIRECTOR M.R.Etchison & Son		ADDRESS <i>Elwood T. Etchison & Son</i> Frederick, Md. 21701	25a. REC'D BY REGISTRAR NOV 3 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15669

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15671

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Urbana	c. LENGTH OF STAY IN lb Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highway near Urbana		d. STREET ADDRESS 513 Nelson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Peter	Middle Terzian	4. DATE OF DEATH November 19 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1928
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Price Electric	9. AGE (In years last birthday) 38 yrs.
13. FATHER'S NAME Aram Terzian		11. BIRTHPLACE (State or foreign country) New York City, N. Y.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alice Terzian (Same as item # 2)	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical-Thoracic Spine; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Transected Aorta		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO Crushed Chest			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision of auto	
20c. TIME OF INJURY Month, Day, Year Hour, o.m. 5:15 p.m. 11-19 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Mr. Urbana - Frederick - Md	
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)
EXAMINER'S NAME (Type) B.O. Thomas, Sr. M.D.		22. DATE SIGNED 11-19-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Bronx, N.Y.
24. FUNERAL DIRECTOR Howard M. Etchison	ADDRESS Judley	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE Charles Judge
M. R. Etchison & Son, Frederick, Maryland		NOV 22 1966	

1001

02021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15670

CERTIFICATE OF DEATH

15672

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2	
3. NAME OF DECEASED (Type or print) HERBERT EUGENE THOMPSON, JR.		4. DATE OF DEATH November 3, 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH 29 June 1922	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herbert E. Thompson		14. MOTHER'S MAIDEN NAME Mary Hawse	
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220 26 0255	
17. INFORMANT Mrs. Vergie L. Thompson (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive failure</i> INTERVAL BETWEEN ONSET AND DEATH 4201 <i>young</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary occlusion & myocardial infarction</i> 72 hours (c) <i>Coronary artery disease</i> <i>Infection</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September, 1966 to 11/3 1966 , that (I) (we) last saw the deceased alive on 11/3 1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>James B. Thomas</i>		22b. DATE SIGNED 4 Nov 1966	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Resthaven Memorial Gardens		23d. LOCATION (City, town or county) (State) Hansonville, Md.	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR NOV 7 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Commonwealth

Commonwealth

(or any or each) member of either said body or cor-

poration

Commonwealth of Massachusetts

Commonwealth

Commonwealth of Massachusetts

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15671

15673

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

7 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1426 W. 11 th., Street

3. NAME OF
DECEASED
(Type or print)First
WILLIAMMiddle
ARTHURLast
THRONE4. DATE
OF
DEATH
Nov. 22

1966

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

October 13, 1882

9. AGE (In years
at birthday)

84

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

YES NO

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Salesman

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Milwaukee, Wisconsin

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William E. Throne

14. MOTHER'S MAIDEN NAME

Rose Ellen Naylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

393-~~XX~~03-1301A

17. INFORMANT

Mr. J. Arthur Throne Rt. # 5 Frederick, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

} (b)

DUE TO

(c)

Hypertensive cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1956 to Nov. 22, 1966, that (I) (we) last saw the deceased alive on Nov. 22, 1966, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas E. Stone

M.D.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.22b. DATE
SIGNED

11-23-66

22c. PHYSICIAN'S
NAME (Type)

Thomas STONE

22d. ADDRESS

Frederick, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11-23-1966

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert E. Dailey & Son

ADDRESS

Frederick, Maryland

25e. REC'D BY REGISTRAR

NOV 28 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

1963

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		15674					
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b				c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick 101											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Route 5				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Helen Futch Tribble				First Middle Last				4. DATE OF DEATH Nov. 12- 19 66				Month Day Year							
5. SEX Female				6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14-1896		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lak City- Florida				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Futch				14. MOTHER'S MAIDEN NAME Talulah Jernigan				Address											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 261- 52-6967				17. INFORMANT Henry R. Tribble-Jr.-Route 5-Frederick, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Amyotrophic Lateral Sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 3561 3 years DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 5, 1966 to Nov. 12, 1966 , that (I) (we) last saw the deceased alive on Nov. 11, 1966 , and that death occurred at 12:10 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE <i>W.J. Riddick</i>				22b. DATE SIGNED 11-12-66															
22c. PHYSICIAN'S NAME (Type) Dr. W.J. Riddick				22d. ADDRESS Frederick Med. Center-Frederick-Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF Nov. 14-1966				23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory				23d. LOCATION (City, town or county) (State) Washington 18- D.C.							
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son				ADDRESS Whitmore Frederick, Md. 21701				25a. REC'D BY REGISTRAR NOV 14 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							

STOOL

WATER

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15673

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15675

1. PLACE OF DEATH O. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Roland Trexell		First Charles	Middle Roland
		Last Trexell	4. DATE OF DEATH Month Nov. Month 20 Day 19 Year 66
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 16, 1907		9. AGE (In years lost birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Clayton J. Trexell		14. MOTHER'S MAIDEN NAME Mary Catherine Lawrence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-5782	
17. INFORMANT Mrs. Charles Masemore Thurment, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 976X DUE TO Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause Gunshot wounds of skull and brain		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-66	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor Cemetery
23d. LOCATION (City or Town) (County) (State) Rocky Ridge Fred. Co. Md		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
24. FUNERAL DIRECTOR Raymond E. Creager Thurment Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

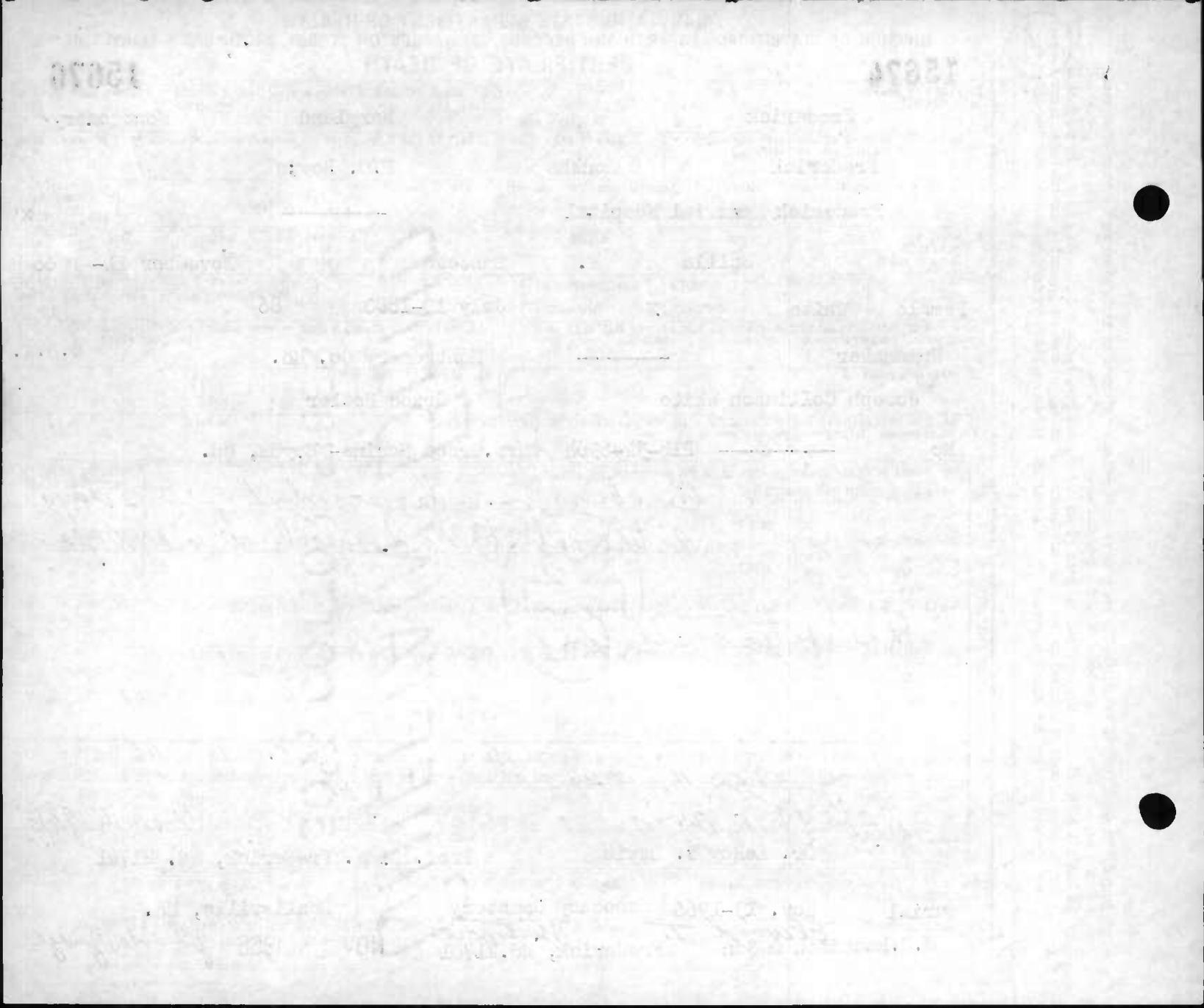
15674

15676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Boyds 15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sallie	Middle E.	Last Umstead
4. DATE OF DEATH	Month November	Day 11	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10-1880
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Montgomery Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Collinson White		14. MOTHER'S MAIDEN NAME Grace Botler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-54-6964	
17. INFORMANT Mrs. Grace Horine- Boyds, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Nov 14, 1966, that (I) (we) last saw the deceased alive on Nov 11, 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE LeRoy T. Davis		22b. DATE SIGNED Nov 11, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. LeRoy T. Davis		22d. ADDRESS Prof. Bldg. Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13-1966	
23c. NAME OF CEMETERY OR CREMATORIAL Monocacy Cemetery		23d. LOCATION (City, town or county) (State) Beallsville, Md.	
24. FUNERAL DIRECTOR Elwood T. ADDRESS Whitmore M.R. Etchison & Son Frederick, Md. 21701		25a. REC'D BY REGISTRAR NOV 15 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15675

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15677

1. PLACE OF DEATH a. COUNTY Frederick		Items 8, 9, 13, 14, 16, 22b, 22c, 22d Film 0382 11/10/66 mh		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE North Carolina b. COUNTY Watauga	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Frederick		c. LENGTH OF STAY IN 1b minutes		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Zionville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Frederick Memorial Hospital				d. STREET ADDRESS Route # 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First TOMMY	Middle MORETZ	Last WINEBARGER	4. DATE OF DEATH	Month November Day 3, Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1936	9. AGE (in years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Worker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Watauga Co. North Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edd Winebarger		14. MOTHER'S MAIDEN NAME Viola Moretz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 243-48-7968		17. INFORMANT Address Hospital Records, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) }		Congestive Heart Failure Compound Fracture of Skull INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision			
20c. TIME OF INJURY Hour <input type="checkbox"/> p.m. 11 - 3 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Frederick - Frederick - Md.		(County) Frederick		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>B.O.Thomas</i>					
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 4 Nov 66					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial		22b. DATE THEREOF 11/6/66		22c. NAME OF CEMETERY OR CREMATORIUM Moretz	
22d. LOCATION (City, town, or county) Zionsville,				(State) North Carolina	
23. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>		ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE NOV 7 1966	
				24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10. *Urtica dioica* L. (Urticaceae) (Fig. 10)

Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15676

CERTIFICATE OF DEATH

15678

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Braddock Heights c. LENGTH OF STAY IN 1b Since 11/23/66		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vindobona Convalescent & Rest Home		d. STREET ADDRESS 113 Record Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELEANOR	Middle NELSON	Last RITCHIE
4. DATE OF DEATH November 26, 1966	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 March 1874
9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME John Ritchie		14. MOTHER'S MAIDEN NAME Betty Maulsby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	16. SOCIAL SECURITY NO. 220 46 1407	17. INFORMANT Philip R. Winebrener (Same as item #2)	Address
No			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Minutes 420.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above.			
22a. SIGNATURE <i>James B. Thomas</i>	22b. DATE SIGNED 28 Nov 1966		
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/29/66	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR <i>Frank R. Smith Jr.</i>	ADDRESS M. R. Etchison & Son, Frederick, Md. 21701	25a. REC'D BY REGISTRAR NOV 29 1966	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>
VR A15 (4) 2DM 1/65			

1001

35801

Information

be obtained

Information

available

available

Information

available

Information

available

available

Information

available

Information

available

available

General information

available

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15677

CERTIFICATE OF DEATH

15679

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Point of Rocks

c. LENGTH OF STAY IN 1b

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Point of Rocks

10-1

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Month

Day

Year

Lake

Wright

Nov. 24-

1966

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

Feb. 19- 1888

9. AGE (In years
last birthday)78
yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles W. Wright

14. MOTHER'S MAIDEN NAME

Mary Jane Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-09-7793

W. Meredith S. Young- 609 Schley Ave.-Frederick

Address

Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Acute myocardial infarction

Arterio-sclerotic heart dis

INTERVAL BETWEEN
ONSET AND DEATH
30 MIN.

15± yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not White at work
p.m. 1920d. INJURY OCCURRED
While Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1961, 19, to 24 Nov., 1966, that (I) (we) last saw the deceased alive on 29 Oct. 1966, and that death occurred at 1:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE

Dr. Charles H. Conley, Jr.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
Nov. 24-196622c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

Prof. Bldg.- Frederick, Md. 21701

23a. BURIAL, CREMATION,
REMOVAL (Specify)
CREMATION

23b. DATE THEREOF

Nov. 25-1966 Fort Lincoln Crematory

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Washington 18, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE

Elwood T. Whitmore
M.R. Etchison & Son
Frederick, Md. 21701

ADDRESS

REC'D BY REGISTRAR

DATE

REGISTRAR'S SIGNATURE

NOV 28 1966

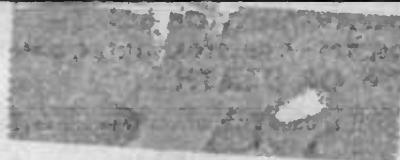
j Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

19658



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15678

CERTIFICATE OF DEATH

15680

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Walkersville

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

40 Fulton Ave.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Month

Day

Year

Hulu

CLARA

WRIGHT

5. SEX

6. COLOR OR RACE

F

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 1, 1905

9. AGE (in years
last birthday)

61 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesclerk

10b. KIND OF BUSINESS OR INDUSTRY

Department store

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Luther C. Putman

14. MOTHER'S MAIDEN NAME

K. Gertrude Barton

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-01-1298

17. INFORMANT

G.C. Barton, Walkersville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

2 hours

IMMEDIATE CAUSE (b)

Coronary thrombosis

2 hours

IMMEDIATE CAUSE (c)

Arteriosclerotic cardiovascular disease

several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OP. CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While Not While
p.m. at work at work

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1966, to Nov. 27, 1966, that (I) (we) last saw the deceased alive on Nov. 27, 1966, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Ernest A. Dettbarn

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

11/28/66

22c. PHYSICIAN'S
NAME (Type)

ERNEST A. DETTBARN

22d. ADDRESS

Walkersville, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/30/66

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Hope cemetery

23d. LOCATION (City, town or county)

Woodsboro

(State)

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

G.C. Barton

ADDRESS

Walkersville, Md.

25a. REC'D BY REGISTRAR

DEC 1 1966

25b. REGISTRAR'S SIGNATURE

J Charles Judge

1961

1961